Harvey Agnew, M.D., Editor

THE CANADIAN HOSPITAL

Toronto, June, 1949 Vol. 26 No. 6

Obiter Dicta

British Hospitals Association Closes Its Doors

IT will be a matter of regret to its many friends in Great Britain and abroad that the British Hospitals Association has found it necessary to terminate its activities as of April 1st of this year. This decision, reached by members at an Extraordinary General Meeting, was an anticipated consequence of the taking over by the Government of the hospitals in Great Britain. This means also the discontinuance of the Central Bureau of Hospital Information, an advisory service of considerable value.

Although on first thought one may wonder why it should be useless to endeavour to maintain the Association, further reflection reveals why this should be. A hospital association has various functions. Some of these such as the pooling of information and other educational activities could be carried on under the new order, but the primary function, that of advancing the interests and welfare of the member hospitals, would be difficult to maintain to any degree of efficacy when all its officers would be directly or indirectly employed by the state. Even though the interests and welfare of the member hospitals really means the welfare of the patients, it would still be difficult for the Association to speak out forcefully and with adequate emphasis if, by so doing, the spokesmen and officers were jeopardizing their own careers. This is an unfortunate situation, for it does appear from this distance as though many matters still need final adjustment and the existence of a free and independent Association, prepared to take up the cudgels on behalf of the hospitals and their patients, would expedite considerably the satisfactory adjustment of many undesirable details.

In contrast, under the socialistic scheme in Saskatchewan, the government has not taken over the hospitals but only provides payment for the patients, with, of course, various controls and safeguards. Although the Government operates the hospital plan, the hospitals preserve their autonomy and the provincial hospital association continues as the spokesman of the hospitals in the many negotiations between the hospitals and the Government. In fact the Government has found it so satisfactory to have one effective channel of contact that it has even suggested assistance to the Association to increase its efficiency.

We understand that those hospitals which were disclaimed from, or not transferable to, the National Health Service in Great Britain, have now formed their own Association of Independent Hospitals and Kindred Organizations. It has been announced, also, that no future editions of the *Hospitals Year Book*, a very valuable reference volume, will be published. One would hope that the Government would continue some of the publications and maintain, in part at least, some of the activities of the Central Bureau of Hospital Information. To the Secretary, Mr. J. P. Wetenhall, and to the other officers and members who have served the field so faithfully through this Association, we extend our sympathy and best wishes.

A Provincial Official Expresses His Views

SO many departmental reports in governmental publications seem to have all colour and independence of thought screened out of them (drained would be a more appropriate term in some instances) that it is highly refreshing to read the report of Dr. D. F. W. Porter, Director of Hospital Services in New Brunswick, to Dr. J. A. Melanson, Chief Medical Officer, as published in the latter's 1948 Report to the New Brunswick Minister of Health and Social Services. Writes Dr. Porter:

"The scope of the work of the Division was very definitely restricted due to inadequate funds, no additional staff, and the diversion of the director's time to

other departmental duties. From May onwards, only the most urgent public hospital requests could be met, and all of the hospitals could not be visited during the year. This loss of direct contact with individual hospitals is to be deplored, for a continuation of the existing circumstances affecting the Division will completely defeat the real purpose for which it was inaugurated."

With respect to plans for an integrated hospital system, Dr. Porter refers to his previous annual report which noted that:

> ". . . there was an urgent need for a detailed hospital survey by an expert outside group. Authority could not be obtained for this (apparently radical?) request. We have, therefore, been faced with the new health grants, necessitating a detailed hospital survey as one of the many requirements of federal authority. It is again emphasized that an outside expert group will be needed to produce the answers. We estimate the survey will require the services of a three-man team for approximately three months. We have, therefore, been forced by circumstances to perform 'lip service' in our attempts to plan for an integrated hospital system."

As for government institutions, "Existing government hospitals showed no great improvement in physical plant or in over-all guiding authority. . . A well defined policy for our government institutions is of very great urgency, for the existing lack of this is by no means a matter of which any department could be proud. Under existing circumstances, the superintendents are 'defeated before they make a start'."

The handling of the details associated with the national health program comes under fire, too:

> "In June, 1948, the New Brunswick Section of the Maritime Hospital Association recommended that the Hospital Planning Committee be named the 'approving body' for the province. However, this very excellent suggestion did not meet with favour and, in September, the hospitals were advised that the government had decided that this responsibility would be delegated to the Department of Health. By the end of October we were advised that the department's decision was not final and each project would have to be submitted to the provincial government.
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> "The original announcement concerning the new health grants contained the most welcome news that there were 'no strings attached'. Many of us felt that at long last Utopia had arrived for those in the public health field. However, this dream faded like the morning mists and we rapidly awakened to a realization that we were approaching the problems by methods lacking even the basic principles of sound planning methods. The lack of decision at provincial level with respect to the hospital construction grant has resulted in such adverse criticism that our public relations with individual hospitals are far less satisfactory than when the Division was formed.
>
> "It is regretted that a contributory plan to assist the financing of existing hospitals did not precede, or run parallel with, the construction grant. As far as the public hospitals of New Brunswick are concerned, the normal sequence of 'cart' and 'horse' has been reversed.
>
> "Yet in spite of the evident pessimism expressed above, it is a comforting fact that governmental bodies have made some visible recognition of the needs of the country's hospitals."

Writing of private hospitals and nursing homes, although legislation has been passed giving the Minister power to draw up regulations for their licensure and control, Dr. Porter recommends "that any action be postponed until a policy has been formulated and properly trained staff be available to supervise this particular group of hospitals". This is common sense.

As long as our government services can attract men of the calibre of Dr. Porter, who combine ability and vision with independence of thought, there is still hope for democracy.

Schools of Administration Set High Standards

AT a meeting in Chicago last month further progress was made in setting standards for the training of hospital administrators. In recent years a number of good university schools have been established in various parts of the continent and, by frequent conferences, experiences have been pooled and a more or less common pattern of procedure evolved. The popularity of these courses and their quick acceptance by the field generally may well lead, however, to the setting up of courses without adequate realization of all that is involved in the assumption of this responsibility. A number of new courses have been set up, or are being contemplated—some apparently excellent and others less promising. In some instances, it would seem better for a contemplated school to endeavour to meet the needs of certain individuals by means of shorter courses rather than to attempt full length courses at the graduate level.

The administrative field may be entering upon an era similar to that experienced by the medical profession when it evolved from the apprenticeship type of training to the academic basis and a number of schools of varying degrees of qualification resulted. Not until the A.M.A. established standards back before the first war was the situation corrected on this continent. The Blue Cross Commission has accomplished a comparable result in giving a hallmark of approval to hospital care plans meeting its rigid standards.

To facilitate this action with regard to education in hospital administration, there has been set up an Association of University Programs in Hospital Administration. The schools participating in the organizational meetings were from the Universities of Chicago, Columbia, Minnesota, Northwestern, Toronto, Washington, and Yale. It is anticipated that certain other schools also may be admitted to membership. Member schools will be expected to maintain rigid requirements both as to the academic training in the first year and the practical training of the second or residency year. The Association will work closely with the American College of Hospital Administrators and with the Kellogg Foundation and other bodies interested in administrative education. Its members have agreed, also, to make their resources as fully available as possible to the College and to hospital associations concerned with the development from time to time of special courses in administration. This action should prove to be another important milestone in the evolution of education and training in hospital administration.

The Necessity for CLOSER RELATIONSHIPS Between SMALL and LARGE Hospitals

With a Summary of the Program of the Rochester Regional Council

Paul A. Lembcke, M.D., M.P.H.,
Associate Director, Council of Rochester Regional Hospitals, Rochester, N.Y.

WHY should there be a closer working relationship between small hospitals and large hospitals or medical centres? The reasons seem clear enough in the case of the small hospitals. Simply because they are *small*, small communities cannot afford the hospital facilities and equipment to handle all contingencies. One cannot afford to own a power mower to cut a patch of lawn 30 by 50 feet, nor a combine to harvest only 10 acres of wheat. However, 30 farms could pool their resources to own a combine to harvest a total acreage of 300, or a large farm could help the smaller ones and benefit itself at the same time.

A more important handicap of the small community and small hospital is the difficulty of attracting and holding people of special and outstanding skills in the fields of medicine, nursing, and hospital administration. This is no reflection on the many men and women who serve so faithfully and well in small hospitals, but it is a fact to be observed and considered. Also, in small communities and hospitals, opportunities and means for a well-rounded and continuous program of post-graduate education do not exist if each community and hospital attempts to function alone, isolated from other hospitals and communities.

The obvious solution to these three basic problems of (1) facilities, (2) specialized services, and (3) education, seems to lie in a *regional association of hospital and medical interests*. Such an association, taking in hospitals both large and small, preferably including a medical school also, should be able to spread more evenly throughout a given region the benefits of modern, progressive medical and hospital care.

Autonomy Can Be Preserved

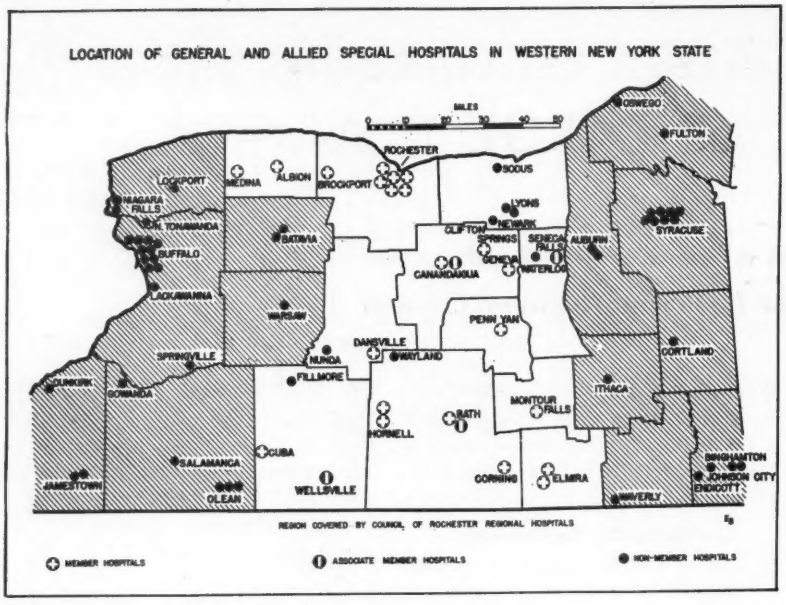
Among the many questions that will occur to you, there are two I shall attempt to answer in advance. The first is: what safeguard can be provided against the small hospitals being swallowed up by the large ones? The answer lies in the voluntary nature of the regional association recommended, and incorporation of the working relationship in a democratically organized group. There is a strength and character in institutions locally conceived and locally directed that we all recognize and cherish. These good qualities of small hospitals and their essential local nature will be safeguarded by a democratic type of organization where each institution, regardless of size, has an equal voice in determining policies.

That is not to say there should never be bi-lateral arrangements between hospitals, such as a large hospital and a small one. On the contrary, in a circumscribed geographic area it is often advisable to have an affiliation so close that in respect to certain departments or functions, the two hospitals function as one. Within the past few years we have seen four such affiliations in the region covered by the Council of Rochester Regional Hospitals, an organization to be described more fully in a later section of this paper. These affiliations have been: (1) between Strong Memorial Hospital (650 beds) and the Park Avenue Hospital (100 beds) for pathology service; (2) between Rochester General Hospital (325 beds) and the new North Park Hospital (120 beds) for nursing education, laundry, laboratory, clinical consultation, resident, and certain administrative services; (3) between Strong Memorial Hospital and the Genesee Hospital (225 beds) for medical teaching, especially of the resident staff; and (4) between Rochester General Hospital and the 30-bed Lakeside Memorial Hospital, 22 miles away, for clinical consultation and certain administrative services.

In the last instance cited, the staff of the smaller hospital will handle only simple and uncomplicated cases. The more difficult and complicated cases will be cared for in the larger institution, in many instances by the physician from the small community, with such additional help as he may require. In general, the smaller hospital will function as a unit of the larger institution, separated by distance but tied together by the same personnel and standards. As a result of this affiliation the people and physicians of the small community will have the special services and high standards of a large hospital, but will retain convenience, the pride of ownership, and the direct, personal responsibilities that are the strong points of local institutions.

We expect affiliations of these general types to develop more and more in future years. I believe

An address delivered at the Sectional Meeting, A.C.S., New York, March, 1949.



The Area Covered by Rochester Program

every hospital in a small community should seek, and would profit by, such affiliation in respect to certain functions. Whether an affiliation between two relatively small hospitals, e.g., one of 50 to 100 beds in one community, with a hospital of 100 beds or so in another community some miles distant, would be profitable, cannot be answered until we have had experience with such an arrangement.

Does the Large Hospital Gain?

The second question I have set myself to answer is: what advantage is it to the larger hospital or medical centre to encourage and participate in a closer working relationship with small hospitals? The large hospital undoubtedly derives some advantages. For example, it may be possible to develop better facilities for training in certain special fields, and to use special equipment and personnel to a greater extent and more efficiently if the small communities and hospitals will turn to the large hospital for such specialized service. An illustration of this point might be a neurosurgical service, or a department of physical medicine.

At the same time, in the type of relationship which characterizes the Council of Rochester Regional Hospitals, the many associations offered by the Council's program have created in the large hospitals a respect for the physician and hospital in the small community. It is recognized that the latter can provide good care for a great majority of patients and conditions, and patients are encouraged to remain in their home communities for the type of care which is within the capabilities of their local hospitals and physicians. As a result of this appreciation of the respective jobs for which small and large hospitals are qualified, patients with conditions which can be cared for satisfactorily in small hospitals tend to remain in their home communities and there is no great economic advantage to the large hospital or medical centre.

Aside from the anticipation of any possible advantages, we can expect the large hospitals to work more closely with smaller hospitals because they realize that it is their duty. The future of the large hospital is tied up with the future of all hospitals; and if small hospitals become discredited in the eyes of the people, all hospitals will suffer thereby. I am confident that we can rely more and more on large hospitals to respond to this duty and obligation; neglect of this duty would be contrary to both their own interests and to the larger objective of service to all mankind.

THE COUNCIL OF ROCHESTER REGIONAL HOSPITALS

The Council of Rochester Regional Hospitals is an experiment set up to study and try

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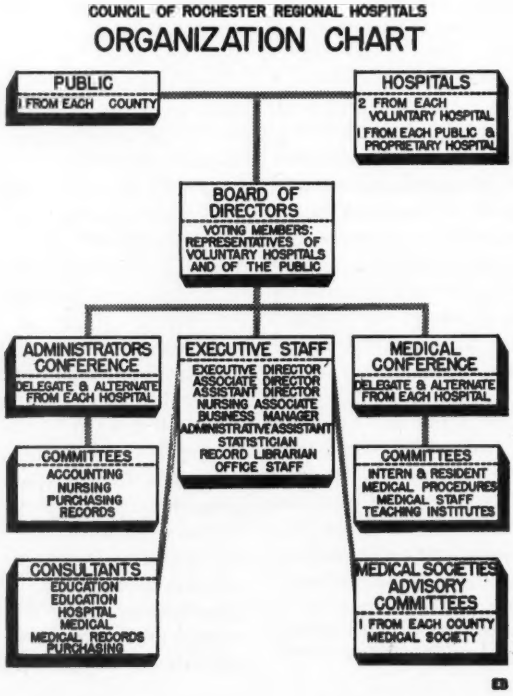

Dominion Plays Supporting Role
in Nation-Wide Health Program

G. D. W. Cameron, M.D., D.P.H.,
Deputy Minister of National Health and Welfare, Ottawa.

UNDER the British North American Act of 1867, the federal government was charged with the duty of caring for "Quarantine and the Establishment and Maintenance of Marine Hospitals." To the provinces was given the responsibility for the Establishment, Maintenance and Management of Hospitals, Asylums, Charities and Eleemosynary Institutions in and for the Provinces". As these matters were understood in those days this was the sum total of government interest in health.

The reason for this somewhat cursory treatment of an important subject is to be found in a glance at public health knowledge and practice of those days. Within a country health was largely a personal matter, and quarantine was still regarded as the main defence against the spread of disease from other countries. Jenner had made his brilliant contribution to the control of smallpox, and there were sporadic efforts to cope with problems of environmental sanitation, but anything even remotely resembling our modern notions of organized health activity simply did not exist. The authors of the B.N.A. Act went as far as they could with the knowledge at their disposal. To succeeding generations has fallen the job of interpreting their intent and evolving a working pattern for the developing problems of our time.

Since 1867 there has been a gradual increase in the role of governments in health work. This has been true everywhere. However, it is also true to say that in Canada we have adhered to our federal constitution as far as health matters are concerned, and the original concept of assigning national tasks to the federal department, and all projects generally associated with local government to the provinces, has been followed. An important point to note is that, while this division of primary responsibility is generally accepted, it would be a mistake to assume that the federal government has no interest or concern for the health of Canadians. We in the department feel that we have a supporting role to play in relation to the provincial departments. Until recently this support largely consisted of technical assistance and co-operation in specific programs.

The 1944 Act to establish a Department of National Health and Welfare states that "co-operation with provincial authorities with a view to the co-ordination of efforts made or proposed for preserving and improving the public health . . ." shall be one of the duties of the new department. The proposals relating to health laid before the Dominion-Provincial Conference in 1945 and the grants program announced in May, 1948, are further evidence of an acceptance by the federal government of responsibility to back up the provincial health authorities with such financial aid as is required from the nation's resources to support the provinces in extending their health programs.

G. D. W. Cameron, M.D., D.P.H.

The results of this generally accepted interpretation of our constitution are probably quite well-known to most of you. Every province has an active health department. These share in varying degree with municipal departments the tasks commonly associated with official health agencies. One of the blessings of a federal system of government is that a number of patterns of operation are under trial at the same time. This is the case in Canada where ten different systems are being followed. The basic elements are the same or similar, the differences lie in the methods of approach. All are concerned with hospitalization for mental disease and tuberculosis, the health of mothers and children, public health nurses and sanitary inspectors, pasteurization and safe water, immunization, V.D. control, and so on. These are the fundamentals of public health; and it is the provinces and the municipalities which provide them for our citizens.

Probably less well known to you is the supporting role the federal department has played and is playing. The health work of the Department of National Health and Welfare can be looked at under two headings: that which relates to exclusively federal responsibilities, and that which is carried on in co-operation with, and in support of, the provinces.

Federal Health Activities

Activities coming under the first heading are: maritime quarantine, to which has been recently added quarantine as applied to international aerial navigation; the care of sick mariners from ships paying dues at our ocean ports; the care of lepers

An address at the Biennial Meeting of the Canadian Hospital Council, Quebec City, May, 1949.

under the terms of the Leprosy Act; the provision of health care for Indians and Eskimos; the administration of the Food and Drugs Act, which has to do with the purity and labelling of all food and drugs offered for sale or sold anywhere in Canada whether made here or imported; the administration of the Proprietary or Patent Medicine Act, and the Opium and Narcotic Drug Act. In addition our public health engineers are responsible for sanitation on common carriers, and since the war we have established a civil service health division. Besides all the above tasks, we provide technical assistance to other branches of government. Our officers perform the medical examinations connected with immigration both abroad and at our ports, and our medical officers advise the Department of Transport on the medical aspects of licensing pilots for aircraft. There are many other jobs which our specialists are called upon to perform but enough has been said, I am sure, to indicate that our statutory responsibilities are not without variety and breadth of interest and that they touch the welfare of many Canadians.

Turning now to the Department's work in co-operation with the provinces: we interpret the Act establishing our department as directing us to function as a central health agency, staffed and competent to supplement and assist provincial departments of health in the carrying on of their tasks — whenever the provinces request our services—and to investigate special problems as deemed necessary, and either instigate or conduct research.

Obviously such a program calls for mutual confidence and co-operation between provincial departments and our own. It is a pleasure to report that our working relationships with provincial staffs are excellent. Possibly our Laboratory of Hygiene offers as good an example of this type of co-operation as any. It works with provincial health laboratories, aiding them where possible, and generally acting as a co-ordinating agency, especially where common standards are desired. The directors of provincial laboratory services meet in Ottawa once a year to discuss their problems and make plans.

In the same relationship to the provincial services are our divisions of child and maternal health, mental health, dental health, nutrition, hospital design, blindness control, venereal disease control, epidemiology, and health education. All have as their objectives the advancement of their particular fields of endeavour by what ever means they can devise—always provided they work with and through their opposite numbers in the provinces.

Since the inauguration of the national health program of grants-in-aid to the provinces, our directorate of health insurance studies, which was established shortly after the present department was formed in 1944, has sprung into vigorous activity. Its first task has been to get under way the program of federal health grants to the provinces. An equally important task, and one which is now under way, is to study the experiences of other countries where health insurance is in operation and to analyze needs and prepare suggestions for similar measures in this country.

To complete and round out our machinery for co-operation with the provinces in the health field, we have a statutory body known as the Dominion Council of Health. It is made up of the nine provincial health officers, plus five others appointed by the Minister of National Health and Welfare, with the deputy minister serving as chairman. This body meets twice a year, and performs the very valuable functions of exchange of information and the prevention of duplication or over-lapping of activities.

Grants-In-Aid

A major step forward in our program of supporting provincial health activity was taken on May 14th last year when the Prime Minister announced that a series of ten grants in aid of public health effort and hospital construction would be made by the federal government to the provinces. It may be of interest to note that these grants follow closely those proposed at the Dominion-Provincial Conference of 1945. However there are certain significant changes. The amounts of some have been increased and specific grants for cancer and hospital construction have been added.

Originally the total amount of these grants was about $30,000,000. This has been increased to take care of the new province of Newfoundland on the same terms as the other provinces.

The grants are all governed by the same principle: they are payable only to provinces for the support of health projects which they propose and carry out under their own direction. You will note that this conforms to the principles outlined earlier. In addition there are two important conditions attached to them, first that they be primarily for new services or the expansion of existing services or, in the case of the hospital construction and cancer grants, that they

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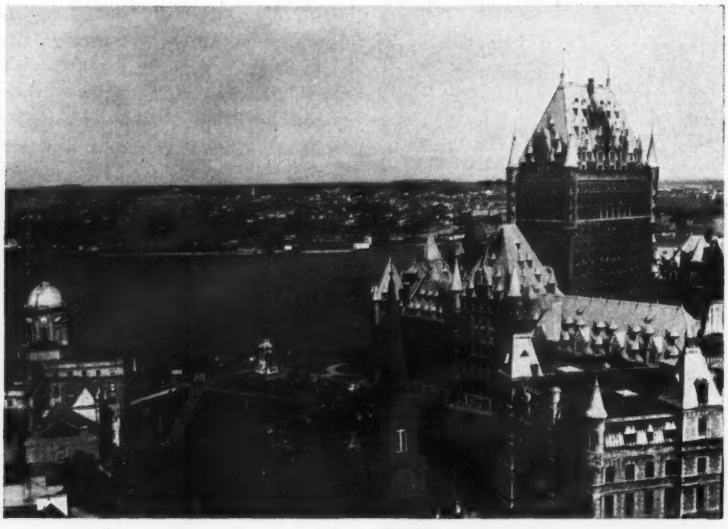

A glimpse of Quebec City showing the Chateau Frontenac and St. Lawrence River.

The NURSE in the RURAL COMMUNITY

Rev. Sister Stella Dube,
Our Lady's Hospital,
Vilna, Alberta.

A SMALL rural community has few possessions and these it takes to its heart. The rural hospital belongs to the community and is an integral part of the village or town in which it is located. It is a subject of common interest among the residents of the district and has a corresponding influence upon local community spirit. Whether or not that spirit is "good" will often depend in large measure upon the nursing personnel of the hospital. In other words, the nurse, particularly a nurse administrator, is a leader in rural areas and must serve the whole community to the best of her ability.

The Nurse as a Leader

In what is her leadership comprised? Not necessarily in appearing on public platforms or in the public press. Her leadership will consist, generally, in the influence she exerts on the little world with which she is in contact. If her influence is to be of value she must develop and maintain fine Christian qualities — kindness, mercy, generosity, sympathy, zeal for her work, nobility of thought and act. These lacking, all the professional skill in the world will not make her a nurse in the ideal sense of the word. She may be able to heal the wounded limb but she will not be able to soothe the overwrought mind of the worried patient, awaken the courage of the depressed, or bring back a smile of contentment to the face of a frightened child. A nurse is more than an expert in making beds and applying medications. She must show by the radiance of her virtue that she is a complete woman in spirit as well as in flesh.

It is true that nurses are called upon to give much of time and energy in their arduous service to the community in which they live. To some it may seem that to work in a small rural hospital would be the burial of their hopes and ambitions. This is far from true. If nurses in training could be given two months experience in a rural hospital before they graduate, there would exist among them a greater understanding of the problems, the compensating joys, and the minor sorrows of rural hospitals and rural communities. Also they would display greater willingness to devote part of their lives to this important section of our country. The great business in the life of a nurse is to do and to do without. Never has there been in the world more discontent than there is in certain sections of this country today, and never has more leisure and more material wealth been found among the people of the same walk of life. The nurse must learn to be satisfied with less of the material in order to enjoy more of the goods of the spirit. The greatest asset the nurse requires is zeal in the carrying on of her chosen profession. It is all too easy for the spirit to lag. Most of us know how close is the borderline beyond which our work becomes a chore.

Conditions are never perfect in any community. If the doctor proves to be a model of his profession, then the handyman is like a long headache in a noisy street. If these two important members of the organization, the doctor and the handyman, are all that can be desired, there will invariably be specific problems, e.g., shingling or lighting. In the midst of any number of upsets, the flame of inspiration must be kept alight. The ideal must not be allowed to die down. The nurse must train herself not to permit the power of circumstance and persons to affect her to the point of discouragement or to murmur "Is it all worthwhile?". The life of a nurse is a glorious career, considered even from the national standpoint. It is a life of service to her country. Those who help to build up the mind and the body of the weak and ill are performing a task of tremendous importance for any nation. Just to imagine the country without nurses for one week gives sufficient food for thought as to the value of the nursing profession to the nation in general and to the local community in particular.

Personal Interest

In the rural district nearly every member of the community will have been inside the walls of the hospital at some time or other. Yet too often there is fear of the unknown on the part of both the patient and his relatives, though it may be disguised. To establish quiet of mind in the patient and to reassure the relatives is one task confronting the nurse. It is a task and a duty and in this she is acting as a public relations officer for her hospital. If she has cultivated warmth in her heart and cordiality in her manner it will not prove difficult. When newcomers are met with friendliness and sympathy, their instinctive dread of the hospital disappears.

In the very small hospital, the doctor and nurses form a unit for the common care of the patient. The family spirit, the informality, and the personal interest in each patient as a member of the same small community, create a relationship between staff and patient that does not weaken when the patient is discharged as cured. Members of the public, on their visits to the hospital, should see the nurse as a lovely light in every room. She should be the embodiment of kindness and mercy. Nurses have always made that the basis of their professional creed; and often the greatest sacrifice, and the one that yields the greatest happiness and return, is that of self discipline. The care of the sick,

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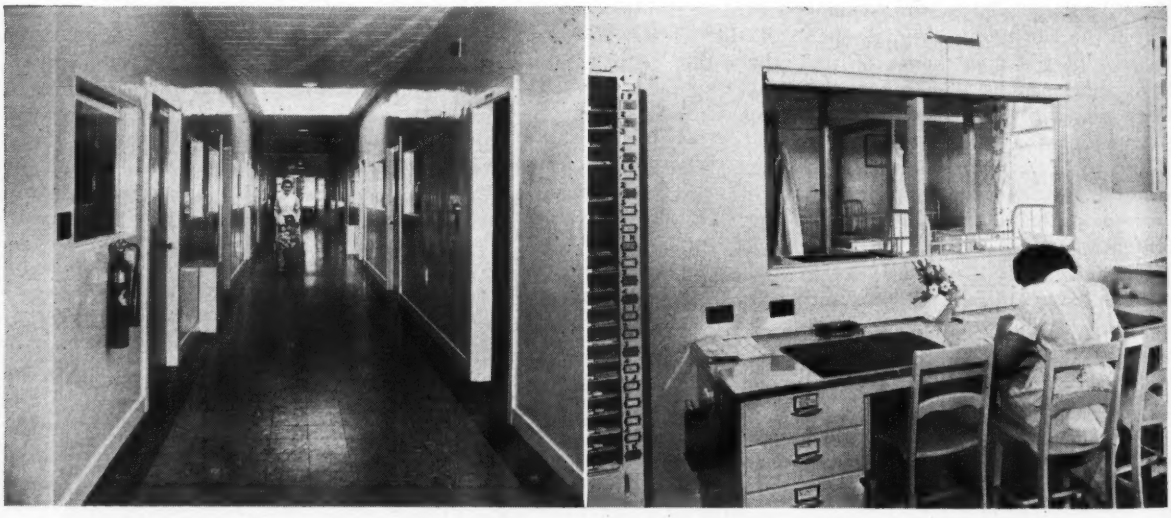
Adapted from an address at the annual meeting of the Associated Hospitals of Alberta, 1948.

Children's Wing, Royal Jubilee Hospital, Victoria.

Maintenance Staff Genii Transform Old Wing to Modern Children's Unit

PRESSED for children's accommodation, the Royal Jubilee Hospital at Victoria, British Columbia, has outdone Aladdin and obtained a new wing from an old. But unlike Aladdin's magical manoeuvres, this project required work, and most of it was done by members of the hospital maintenance department staff under the direction of Mr. M. J. Madeley, chief of the department, who designed the new building. The wing was opened seven months after commencement of reconstruction and provides accommodation for 44 patients.

The Strathcona Wing, built in 1905 of solid brick and stone, was a single storey structure connected by a corridor to the main building. This wing afforded an excellent foundation for the children's unit. A new roof with sky-light, modern windows, and a wealth of plate glass along the interior corridor, give a bright, cheery atmosphere throughout. The original large rooms, once heated by cozy corner fireplaces, were redecorated and converted into nine 4-bed wards, one private room, and a nursery for seven babies. The building also



Left, the corridor. Right, windows above desk permit observation of ward.

contains a large sunroom, treatment room, reception room, and kitchen.

Rooms, with acoustic tile ceilings, are decorated in pastel tones and furniture is in deep cream; floors are of grey and blue asphalt tile. Murals depicting woodland folk in a rustic setting adorn the walls. Many of the little elves and tiny animals in these decorations become apparent only after detailed study, and provide a continuous source of interest for the young patients.

Several unusual features are incorporated in this new ward. The bath is elevated on a tile platform to simplify bathing of the children, and small flush toilets to accommodate the young occupants are installed. Floors in the treatment room, kitchen, and utility room, are of non-skid tile. Between the chart room and the nursery is a large plate glass window. The sunroom is equipped with children's furniture and a large toy box constructed in the hospital workshops. Adult furniture is also provided in this room.

The Children's Sunroom.

A small room near the nurses' station was furnished by the children's ward auxiliary as a compact interviewing room.

The cost of the alterations was $41,000, with an additional $6,000 for equipment. One-third of the cost was contributed by the provincial government, and $9,000 is to be given by the federal government. The balance of the funds was contributed by local citizens and organizations.

Province of P.E.I. Now Has Hospital Act

A hospital act was passed by the Legislature of Prince Edward Island at its recent session. This province, being small and having had but a limited number of hospitals, has carried on very satisfactorily without a hospital act for many years, the hospitals coming directly under the Department of Health and Welfare.

The act includes many of the features found in other provincial hospital acts but there are a number of differences. Prince Edward Island does not have municipal and county health arrangements as in other provinces. The province acts as one health unit and sub-governmental authority is confined to the city of Charlottetown and seven incorporated towns. The act does not lay down, nor exercise, authority indicating payments to be made by these small municipal corporations.

A hospital is defined as an institution with a bed capacity of at least twenty beds. Because of the short distances in this province, the government presumably does not desire to encourage the building of units that are too small to permit efficient service.

The arrangement for provincial assistance to hospitals provides that where the total number of days treatment in a year does not exceed 6,666, the sum of $5,000 will be granted. Where the total number of days treatment exceeds this figure, the sum of 75 cents per patient per diem will be contributed.

The period of limitation within which action must be taken against a hospital for reasons of negligence is set at one year after the cause of action arises.

Tumour Registry Created to Aid Cancer Institute

A central tumour registry has been established at the federal Laboratory of Hygiene, Ottawa, to assist in the general program of the National Cancer Institute of Canada. Dr. Desmond Magner, professor of pathology at the University of Ottawa, has been named registrar of the new department.

In addition to other work in this field, the registry will assist pathologists in the classification of various cancers and other tumours and will collect case histories and other relative data for future studies. A panel of leading consultants from all across Canada has been appointed to act as a technical group for the classification of tumours.

Death of Dr. A. E. Archer

As we go to press word has been received that Dr. A. E. Archer of Lamont, Alberta, died on May 23rd from coronary occlusion. Though he had suffered earlier attacks, Dr. Archer carried on with his work until the week of his death. Because of his extraordinary contributions to the health field of this country and because of his warm personality, his loss will be deeply felt all across Canada. (Further comment upon Dr. Archer's life work will appear in the July issue.)

Fire Prevention *in Hospital Design*

H. G. Hughes,
Chief, Hospital Design Division, Department of National Health and Welfare, Ottawa.

FIRE prevention in hospitals embraces more than the literal interpretation of the words. To me it means the complete story, from reducing the possibility of fire, to removing patients, should a fire occur and not be brought under control.

The hospital board is responsible for the care of patients and this includes their safety. It is the board's responsibility to see that a reasonable margin of safety from fire is assured.

It would seem that there are four major divisions into which this subject may be divided:

1. There is the problem of reducing the possibility of fire when the original design of the hospital is worked out;
2. A reliable method of discovering a fire in its incipient stage;
3. Adequate method of rapidly combatting a fire;
4. Speedy and safe method of evacuating patients if the fire cannot be quickly brought under control.

Reducing Possibility of Fire

One of the major factors in reducing the possibility of fire is the use of fire resistant materials in the construction of the hospital. For economic reasons, this is not always possible; if not, it is hoped that the danger spots where a fire is likely to originate in a building will be adequately protected. Another factor in this regard is constant vigilance on the part of those in authority to reduce carelessness that may lead to a fire.

The main structure of the great majority of our larger hospitals is either reinforced concrete or steel, with concrete floors and some type of brick curtain walls and partitions, but we know that such a structure alone is no guarantee of life safety, as witness the disastrous fire at the LaSalle Hotel, Chicago, 1946, or the Crile Clinic, Cleveland, with a life loss of 125. In this disaster not one life was lost through contact with fire.

An important point then, which should always be borne in mind when considering the possibility of fire in hospitals, is that smoke and hot gases create a greater hazard to the patient population of a hospital than immediate contact with the fire itself. Records show that approximately 80 per cent of persons who are victims of fire die from suffocation by smoke or hot gases rather than from burns. An example of this type of fire occurred last year in the St. Vincent's Hospital, Ottawa. There an electrical transformer or its wiring caused an explosion blowing out doors and igniting stored materials, thus allowing heavy smoke to pass rapidly throughout the hospital. Although the fire was contained within a concrete area, the burning of stored blankets, towels, paper, et cetera, caused such heat and smoke that it was impossible to approach the area from the only door. A hole had to be drilled through the concrete floor above and the fire extinguished from there.

Many of our smaller hospitals are of frame construction, but with proper precautions in the design of the building, they may not be as dangerous as a brick veneer structure which, from the exterior, appears to be a fire resistant building and, consequently, is liable to lull those responsible for its safety into a state of false security. St. Anthony's Hospital, Effingham, Illinois, where the recent fire occurred, was this type of structure, except that here the walls were bearing walls with wood joists and studding.

There are certain areas in a hospital that are likely places where a fire might originate, such as the boiler room, kitchen, ward pantries, vertical shafts, and in those storage areas that are not visited constantly. There are also other places where a fire could get under way before it would be noticed and brought under control. These are blocked off areas in a building such as would be found under a gabled or pitched roof.

For this reason, the Dominion Government Regulations* suggest that basements be of fire resistant construction with a concrete floor above. If cost prohibits this type of construction, then the boiler rooms attached to, or forming part of, a hospital should have walls, floors, and ceiling, of fire resistant material and should be cut off from the building by means of a self-closing fire door.

The basement of any hospital is a danger area for fire, not only because the heating unit, electrical equipment, and kitchens, are often there, but because such areas as the paint shop, carpentry shop, and storage rooms, are apt to collect debris of all kinds. Then there are also storage rooms that are not continuously in use. These are places where sprinkler systems, properly installed, maintained, and supervised, should be located. The initial cost of such installations will be paid for in a few years by savings on fire insurance premiums. An example of such a saving was that of a woollen mill in Hull, P.Q., where prior to the installation of a sprinkler system the insurance rate was $3.75 per $100 and after the installation, it was reduced to 45 cents per $100.

Even if a small hospital has not installed a sprinkler system, it should have sprinkler heads in laundry chutes and elevator shafts connected to the domestic water supply. There has been some objection to placing sprinklers in elevator shafts due to

An address at the Dominion Fire Prevention Association Meeting held in Regina, last month.

**The payment of grants for construction purposes by the Dominion government involves a responsibility upon it to see that the money is wisely spent, which means that hospital buildings must be of a type and kind that is satisfactory for the purpose for which they are intended. To assist those who are responsible for the construction and operation of our hospitals, certain standards have been adopted, and included in these is a section on fire prevention.* *(See page 76.)*

the possibility of accidental discharge and damage to expensive equipment. This difficulty should be studied by manufacturers with a view to working out a satisfactory method of protecting elevator shafts. In this regard, it might be noted that there was no sprinkler protection in the Effingham hospital, and further, that there was evidence that the flames leaped upward through the laundry chute fed by fresh paint and varnish.

The Dominion Regulations state in part: "No patient shall be accommodated or treated above the first storey in any hospital building, if the building is constructed wholly or mainly of wood."

This is a most important clause for, to me, its enforcement may well be instrumental in saving Canadian lives. Let us turn again to the recent tragedy at Effingham and see what the report on the fire says in this regard:

"Twelve persons, including an expectant mother, leaped from flaming windows. One was killed and several injured in their falls. Others were helped from first floor windows. None of the hospital's six fire escapes were used."

It was also stated in the report that the Sister who put in the alarm found the whole hall in flames and another statement by a rescuer was that "it burned so fast it couldn't be fought".

This speed of fire-spread is a particular problem we have to face here in Canada in our winter months, when the difference of outside temperature and the heat caused by a fire creates such a tremendous draught that a frame structure can be completely engulfed in a matter of minutes. An example of this was the burning of an army hut in Churchill with such rapidity that two persons were unable to escape even though it was a one-storey building. I must add, however, that piled up snow blocked escape from the windows and the only exit was cut off by flames. Another example was the burning of the Indian Hospital at Fort Norman when an unattended oil heater started the fire at 8 a.m. The temperature was 35 degrees below zero and the 3-storey building was completely demolished in half an hour. No lives were lost owing to the presence of mind of the nursing staff who moved all patients down to the front door before allowing it to be opened. All the patients were then quickly taken out of the building. If the door had been opened earlier the fire would have got a head start due to the draught, and patients might have been trapped on the upper floors.

Nevertheless, it is obvious that a person has a much better chance of survival when all that is required is to close a door, open a window, and step to the ground. Unfortunately, in a hospital, not all patients are able to do just that. They may be too ill, either post-operative cases or fracture cases. These patients require help. They can be taken out on their beds or mattresses, or on a person's back, for even if a leg had to be reset the next day, it would be better than losing a life. One hospital superintendent informed me that 20-25 per cent of his patients would require some form of assistance in order to leave the building quickly.

Discovering Fire Early

Speed is obviously the great essential when coping with fire. Its spread resembles a geometric progression, and early discovery and rapid combatting of it are the aims of all concerned.

If heat-actuated electrical alarm systems are installed in locations subject to incipient fires and in isolated areas, with signal alarms throughout the hospital and also a direct alarm to the Fire Station (if there is one), the fire is detected quickly and can be fought in its early stages.

But preventing the spread of fire is a part of the problem of the architect when designing a hospital. Naturally, he thinks of fire resistant materials as the ideal. If the structure is to be of wood, then fire walls with automatic fire doors are considered in order to zone or block off various wings. These walls should project well beyond the roof and frame walls of the building. Fire stops in the stud walls are essential to stop spread of fire behind the wall surface. They usually consist of 2-inch by 4-inch pieces set between the studding at each floor level. They act to cut off draughts within the walls and help to stop the spread of smoke and fire. If walls are not filled with non-combustible insulating material, and fire stops are not used, fire originating in the basement can spread inside walls and involve a major portion of the building prior to discovery and, therefore, reduce the opportunity of escape for the inmates of the building. The architect might well consider the blocking off of long corridors by means of cross partitions and doors in order to prevent the spread of smoke and to reduce draughts.

As mentioned previously, vertical shafts in a building constitute a grave danger. Careless, thoughtless people have often been known to drop a cigarette butt down the laundry chute, probably thinking it was a refuse chute. These shafts are also a repository for empty cigarette boxes, odd paper wrappers, et cetera, which increase the fire hazard. All such vertical chutes should be lined with fire resistant material and any doors into it should be of metal, or metal clad, and fitted with a self-closing device. And may I repeat that all such shafts should have a sprinkler head of 160 degrees fusing set into the top of each such vertical opening and perhaps two heads in each elevator shaft. Many a fire has been put out before it could really get under way by this simple precaution.

Now a word about chimneys. It has always been my practice to include vitrified flue linings for all chimneys in residence work. In our smaller hospitals and nursing units, this should be the rule. In larger installations, chimneys should have a fire brick lining. There are fewer joints with flue linings but they must be carefully set so that such joints do not leak. Chimneys should ex-

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An Administrator Considers the TRUSTEE and his JOB

Leigh J. Crozier, M.D., C.M.,
Chicago, Ill.,
Formerly Administrator,
Victoria Hospital, London.

A TRUSTEE is a caretaker, a steward, a person who holds property in trust. It is his business to discharge that trust for the sole benefit of the institution and those it serves.

In the initial issue of *Trustee* (October, 1947) Dr. Malcolm T. MacEachern presented "A Code for Trustees". He stressed:

1. The hospital trustee accepts with his appointment a personal obligation to help improve service to the sick and injured.

2. The trustee will know his hospital —its functional structure and its policies in order to make progressive administration possible.

3. The trustee will lend all possible support to the hospital in its role as a centre of education.

4. The trustee will lend all possible support in advancing his hospital through the accepted standards.

5. The trustee will maintain a personal interest in the hospital's public service responsibilities for a healthier people, and will also concern himself with promoting good public relations.

6. The trustee will avoid participation in any hospital activity that would result in financial benefit to himself.

7. The trustee will find ways of discharging his own obligations to the hospital without impairing the work of those to whom administrative responsibilities have been assigned.

To "sit" on the board of a hospital no longer describes the obligation of the trustee. His function is to decide on the important questions of policy which arise out of changing circumstances and conditions in such a way that the major purposes of the hospital can be steadfastly pursued. But, in being a policy maker only, he is not realizing the full possibilities of his position. His slogan should be, "what is done in his hospital should be done for the good of the whole community, for by its work it will be known, and through its good works will it be known as an example and an inspiration to other institutions across the land".

An address at the Ontario Hospital Association Convention in Toronto, November, 1948.

Unfortunately, we hear about a few undesirable trustees, (1) the indifferent, uninterested type who pays too little attention to the hospital, (2) the meddlesome trustee who interferes too much in the detailed operation of the hospital. Impaired functioning will result from over-active participation of trustees in administrative affairs. There is a happy medium. Trustees for the most part do not interfere in administrative matters and concern themselves only with board-level problems. The efforts of the trustee must be directed toward the attainment of an ideal in organization where administrative detail rests with the administrative staff, and to the perfection of an organization in which the whole staff and the doctors can work with a minimum of interference.

"All of us who work in and with hospitals have much to learn from each other. The need for the education of the trustee, especially of the new trustee, is obvious, but trustees with their more objective viewpoint can educate us too."

Qualifications for Trusteeship

In the selection of trustees, no individual should be considered unless he meets certain qualifications. (1) He should have made, or be making, a real success of his own business or profession. (2) He must have a high reputation in the community with respect to his own personal life and his business and professional activities. (3) He should have had some experience in handling "other people's money" as well as his own. Financial problems confronting every hospital are many and varied. Buildings are operated, repairs required, supplies purchased, professional and service help employed, customers (patients) served, and countless other business functions performed, all involving monies. (4) Trustees must have a keenly developed sense of fair play, breadth of vision, and must be willing to understand and abide by the best business and professional ethics. The trustee must have a willingness to discard all self interest and be prepared to spend a substantial part of his time and ability in serving the hospital. (5) Other qualifications are: interest in hospitals, willingness to serve and to co-operate, industry, leadership, good health, adaptability, and progressiveness.

The Ideal Board

The ideal board is one whose members are carefully selected and then prepared for their responsibilities. In this province with approximately 120 general hospitals, the size of the governing board follows no definite pattern. A board should be large enough to represent major interests in the community, yet small enough to function efficiently. From an administrative viewpoint members should be chosen partly on a basis of training and experience in the fields in which the hospital has interests, and partly for having the qualifications outlined above. They should be representative of the entire community. Bringing together leaders representing a wide variety of business and professional interests is bound to add vigour to the board and broaden its conception of the work to be done.

From nine to twelve members would appear to be the ideal size and these should be selected to represent

the leading major interests of the hospital. It is agreed that a three-year term on a rotation basis promotes continued activity and interest of the board. Further terms of three years are recommended to all deserving trustees.

On the board of Victoria Hospital, London, there are three representatives elected by open municipal public vote, one being elected each year. The disadvantage of this is that the hospital is kept in the political arena, not to mention the extra expense of election costs. Personally, I favour a board consisting of appointed members, the only elected members being those chosen by the votes of members of the association. The superintendent of the hospital acts as the secretary of the board and is present at all meetings, but without vote.

Suggestions for Board Improvement

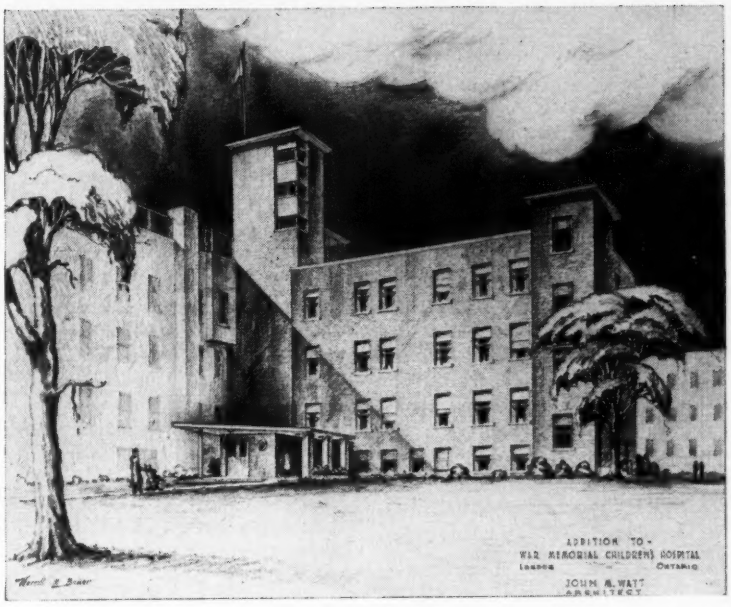
In a recent survey of what administrators think of boards it is interesting that, in most cases, boards were rated as "excellent" or "good". Suggestions put forward by these men and women to improve boards include: (1) Retire chairman—he is too old; (2) Put a woman on the board; (3) Remind a member he is only one member of the board; (4) Ask members of the board not to answer questions unless they know the answers; (5) Keep members from making promises that they cannot keep to doctors, employees, and the public; (6) Have smaller boards; (7) Do not accept blindly any recommendation made by any individual doctor on the hospital staff; (8) Lengthy term on boards results in overbalance of elderly men and women; (9) In our hospital the public relations and educational programs are inadequate; we need a more positive approach; (10) My board is cold, unresponsive, unreceptive, the human quality is leaving our hospital; my employees all have a feeling of insecurity; we need new blood on our board; (11) One superintendent is unable to find an answer to an oft repeated statement by medical staff members and others, "I would not have your job for anything"; board members can do much to add dignity, respect and perhaps a little glamour to the position of executive head of their hospital; (12) The board should not be a mere rubber stamp for a municipal or county council.

Keeping the Trustee Informed

The administrator, with his special knowledge of hospital administration, can do much to interpret the hospital to the trustees. This can be done in various ways. Provide him with thorough information about the hospital, and with the minutes of all meetings of the board, the executive committee, and special committees. Reports given in non-professional terms will help the trustee to understand readily the meaning of the work described.

Every trustee should be on the mailing list of the hospital. Give him the best of the current hospital magazines. If the hospital issues a booklet, let the trustee read it. Reprints from periodicals should be sent to him; these, in turn, should be discussed later in meetings. The trustee will profit by receiving any bulletins which pertain to the hospital, particularly those which deal with personnel, public relations, accounting, medical social work, et cetera. They should be told about all contributions to the hospital and given an opportunity to read the "letters of thanks" sent out. They might even be helped if they received a copy of the collection letters which are used for delinquent accounts.

(Concluded on page 86)



Children's Hospital in Western Ontario Commences New Addition

Marking an important milestone in the history of the War Memorial Children's Hospital, London, the sod was turned in May for construction of a new wing. Designed to add 50 beds to the original 80, the new building will include a children's clinic section, a laboratory and an x-ray department. One of the two modern elevators, which are to be installed in the three-storey wing, will operate from the basement to the roof garden playground. Alterations to the present building provide for new nurses' stations on all floors, modern equipment for the children's diet kitchen and the main kitchen, and a renovated refrigeration system.

It is estimated that the complete project will cost in the neighbourhood of $485,000 and provincial and federal governments are allocating $100,000 from construction grants. The balance of the money is being raised by subscription from citizens and firms of London and western Ontario. The architect is John M. Watt of London.

Expansion of Activities Approved by Delegates

Canadian Hospital Council

Considers Topics of Timely Concern

Jessie Fraser

DELEGATES to the 10th biennial conference of the Canadian Hospital Council held in Quebec City on May 26, 27, and 28, voted this meeting to be the best yet. For three full days there was concentrated debate on various phases of hospital administration and problems of deep concern to hospital authorities. Approximately 150 delegates, federal and provincial government officials, representatives of allied organizations, and guests were registered and, despite the lures of Quebec City and the mighty St. Lawrence, the conference room was packed for every session. Under the able guidance of the President, Mr. A. J. Swanson of Toronto, a long program was completed on schedule, though eloquence ran so freely that here and there considerable firmness was required to keep speakers within their time limits.

It is worthy of note that more individual hospitals sent representatives to sit in at these informative sessions than has ever been the case before at Council meetings. Two guests from Newfoundland, Mr. D. L. Butler and Dr. R. E. Bennett of the Department of Public Health of that province, were given a hearty reception.

Dr. Berchmans Paquet, Medical Director of the City, extended a warm welcome to the delegates on behalf of the citizens of the "ancient capital of French Canada", stating that the importance of the work of the Council and the large attendance were a guarantee of the meeting's success.

In his presidential address, Mr. Swanson expressed, on behalf of the hospitals, their gratification at the increasing interest of government bodies in the health of the people at large and affirmed their deep appreciation of the assistance being received under the Federal Health Program. He underlined the fact, also, that hospitals are "still paying disturbingly high costs for commodities and services and that it is not possible to continue to increase rates . . . for services to a much higher level than at present". In view of inflated operating costs, he was strongly of the opinion that governments, therefore, might go further than to subsidize bed accommodation only and give some assistance in the extension of facilities and services, particularly in providing residence accommodation for nurses. "It is felt", he said, "that hospitals are making a great contribution in the training of these girls without (in addition) having to find all the capital money to build nurses' residences".

R. Fraser Armstrong, Kingston, Ont., who succeeds A. J. Swanson as President of the C.H.C.

Dr. Harvey Agnew, Executive Secretary of the Council, reviewed the activities of the Council since the 1947 meeting and made particular reference to the National Consultative Committee, representing various voluntary organizations, which was set up as an advisory body in connection with the National Health Program. He mentioned also the work of the Canadian Medical Co-ordinating Committee, of which the Council is a member, and which was organized to study the means of maintaining services and the emergency training of their personnel in case of war.

Both the president's address and the secretary's report of Council activities will be published in the July issue.

Shortage of Nurses

Canada is faced with a permanent, not a temporary, shortage of nurses, in the opinion of Miss Edith Young of Ottawa, chairman of the Committee on Nursing. This situation will grow progressively worse in spite of an impressive increase in student enrolment in recent years. Her report indicated that working conditions in some hospitals and salary schedules must be further improved to maintain nursing staffs. "We must conserve existing nursing services and augment them with auxiliary workers in those phases of nursing services which these workers can satisfactorily perform." Going

Newly Elected Members C.H.C. Executive

Percy Ward, Vancouver.

Rev. Sister Ignatius, Antigonish, N.S.

Father Hector L. Bertrand, Montreal.

further, the report said, "It is questionable whether luxury private duty nursing in the hospital should continue as at present". The idea of "group or shared" nursing should be studied. Under this system all patients would receive whatever number of hours of private nursing might be required for their needs. These private nurses would be engaged by the hospital and when not employed for private duty they could contribute to floor duty or any type of work in which their skills would be most valuable.

According to the report, "It is the joint responsibility of the hospitals and the medical and nursing professions to inform the public of the present emergency situation and enlist their assistance in demanding a national survey of health needs."

Miss Gertrude Hall, General Secretary, Canadian Nurses' Association, noted that, while in most provinces there are nurse representatives on the provincial survey committees, or nurse liaison committees assisting them, the overall picture can never be assessed until a nation-wide survey is implemented.

Views varied on the wisdom of the shortened course of training. Sister Mary Claire of Vancouver reminded her listeners that, while nurses may learn certain techniques rapidly, no short course will prepare girls for a proper psychological approach to patient care. We must not, she said, streamline the production of nurses to a point where nurse education, as such, will become a mere skeleton. Miss Agnes MacLeod of Ottawa, speaking of the shortage of instructors, hoped that "before long we may get some support in the nursing field at the university level for those people who wish to go on to higher levels of professional activity". Rev. Sister Ferdinand of Mastai, P.Q., also presented a lively discourse on the future of nursing education.

Construction Trends

Mr. H. Gordon Hughes, Chief, Hospital Design Division, Department of National Health and Welfare, stated that builders preferred to use reinforced concrete or structural steel. Building boards and plywood of various types are very popular for certain uses, but plastics have limited usefulness in hospital construction. As an aid to fire prevention, any corridor as long as 150 feet should be partitioned to cut off draughts. Mr. Hughes reminded hospital people that early ambulation as advocated today makes it essential to supply more toilet facilities in hospitals than formerly. Moreover, in planning wards, both drinking and washing water should be made available within 20 feet of any point in the ward. The nursing time conserved outweighs any extra expense so involved.

Mr. Hughes mentioned the possibilities of an electrically operated bed which can be moved up and down to any desired level. Unfortunately, as yet the price is almost prohibitive. As for dietary departments, larger centres may develop central deep freeze units to serve several institutions. Smooth, well-planned traffic routing in kitchens is essential to speed up service and prevent frayed tempers. Hospitals of tomorrow may have electronic stoves. Even now they can be purchased for $1,800, but may be reduced ultimately to about $400.

Blue Cross Plans

Under the chairmanship of Mr. E. D. Millican, Executive Director of the Quebec Hospital Service Association, one session dealt with problems common to hospitals and Blue Cross.

Discussion was led by Mr. R. S. Chartrand of the Quebec Plan, and by Dr. F. W. Routley of the Ontario Plan. As for the subject of increased use, it was pointed out that Blue Cross utilization has not risen as rapidly as has the incidence per thousand for the population as a whole and that it is up to the doctors to control unnecessary admissions and utilization. As any misuse may well be a moral

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DES VISITES A L'HOPITAL

Part II

VISITEURS VENANT DE L'EXTERIEUR DE L'HOPITAL.

S. S-Adolphe, O.S.A.,
R.N., C.Sc.H.,
Surintendante, Hôtel-Dieu de Québec, Québec.

LE *problème* des visites va de pair avec l'avancement rapide de la médecine et grandit proportionnellement aux progrès accomplis dans les hôpitaux, tant au point de vue traitement qu'au point de vue administration. Or, malgré ces progrès, la guérison du malade reste très incertaine, si on ne peut lui assurer un minimum de repos, de paix et de tranquillité. Mais comment lui assurer ce minimum, si les visiteurs ne cessent d'aller et venir augmentant ainsi le bruit continuel dans les chambres et les corridors d'hôpitaux.

La plupart des visiteurs se présentent munis des meilleures intentions —ces bonnes intentions dont on dit qu'elles pavent un certain endroit au climate torride! Mais ces bonnes intentions peuvent donner et souvent même donnent des résultats entièrement opposés aux résultats attendus, lorsqu'un malheureux malade en est l'objet.

Un autre point difficile qu'il ne faut pas oublier, c'est le fait qu'aucun visiteur n'admettra qu'il ne soit le type même du visiteur idéal, tant il est vrai que nous ne connaissons jamais en nous-mêmes les défauts que nous découvrons si facilement chez les autres.

Et ceci nous amène à parler de *la visite muisible.*

La visite nuisible

Certains malades ont à subir des reproches amers sur la situation financière de la famille; on leur laisse voir un visage fermé, un regard dur, comme s'ils étaient responsables de leurs malades. Représentons-nous l'action déprimante d'une telle visite: ce visité se sent à charge, pourrait-il vouloir guérir, désirer vivre? Par contre, il n'est pas rare de rencontrer des manifestations tout opposées, "L'excès en bien est un défaut". Ce sont des démonstrations intarissables ou des attentions excessives qui ne laissent pas de réprit, qui épuisent physiquement et moralement, créant une vraie tension nerveuse. Le malade lui-même ne peut s'empêcher de demander de la tranquillité.

Si l'évolution de la maladie peut-être retardée par une visite importune, il appartient au médecin de la supprimer. S'il remarque, par exemple, que telle visite, par son effet préjudiciable, annuelle le travail constructif du médicin, il doit l'interdire jusqu'à ce que le malade n'en souffre plus.

"Autant une visite amicale, courte et sympathique apporte du soleil au pauvre coeur humain blessé par la maladie, autant telle autre, oblieuse du sens et de la mesure, lui est ennuyeuse, le lasse et l'assombrit.

"Les soucis et les tracas de la maison sont sources d'accablement et qui sait . . . cause du retard de la guérison. L'air confiné, le bruit sont préjudiciables et les visiteurs les apportent l'un et l'autre."*

Dans *Hospital Management* (novembre 1938) on fait connaître avec beaucoup d'humour quelques genres de visiteurs peu désirables. Je ne résiste pas au désir de vous les présenter.

La visite *encourageante,* si elle n'est pas la pire, elle est du moins celle qui cause le plus d'ennuis. Elle arrive à grands pas, la tête haute, en repirant profondément, la figure figée en un rire résolu. Elle entre dans la chambre au moment le plus mal choisi et se met aussitôt en frais "d'encourager" la malade. Elle se flatte en son for intérieur du fait que sa vitalité à elle, fait contraste auprès de la mine fatiguée de la patiente; elle crie sa force et son énergie, ne perd pas la malade des yeux et s'enquiert: "Comment allez-vous?" alors qu'elle voudrait dire: "Voyez comme je suis forte et bien portante." Elle ne s'arrête pas de parler afin que la chère malade se ménage. Elle est tout simplement étonnée de voir comment la malade a meilleure mine—mais elle "est presque sortie de l'hôpital" et a bien de la chance de n'avoir rien d'autre à faire que de se reposer dans une belle chambre au milieu d'infirmières et d'internes qui sont là pour la servir. "En somme c'est un plaisir d'être hospitalisé et elle va même se chercher un beau petit microbe qui lui permettra de venir se reposer au même hôpital." Elle est prête à parier que la patiente n'est pas vraiment malade, car elle a l'air trop bien. Et elle sait qu'aussitôt libérée, la pauvre convalescente sera aussi "forte et bien portante" qu'elle-même.

A son départ cette visiteuse tient à s'assurer qu' une fois de plus elle n'est pas venue en vain et répète, en soulignant chaque mot, cette recommandation: "Ne te tracasse pas du tout, il ne faut jamais dire que tout est fini." Et elle quitte la chambre de la malade, certaine que sa courte visite a embelli la journée de cette malheureuse femme qui, "c'est à voir au premier coup d'oeil, ne s'en tirera pas." La patiente se dit aussi que son rétablissement sera douteux s'il lui faut subir une autre visite pareille, car cette visiteuse si sémillante et pleine d'allant a emporté avec elle le peu de force que possédait la malade.

Le deuxième des visiteurs peu désirables, c'est le type à mine *triste* et allongée qui s'apitoie sans cesse sur le sort du malade et s'efforce de lui faire croire que son état est pire encore qu'il ne se l'imagine. A leur entrée dans la chambre, ces visiteurs s'arrêtent brusquement, examinent le malade, se surprennent de sa mine et le lui disent aussitôt. S'il objecte qu'il se sent bien, ils secouent la tête d'un air grave et lui remettent à la mémoire que "Jacques, lui aussi, se sentait pas mal un peu avant sa mort." Ils s'enquièrent si le médecin a passé le matin, s'il ne vaudrait pas mieux le prévenir. Ils ne veulent pas être longtemps et s'ils avaient su, ne seraient pas venus du tout. Ils espèrent bien que le malade sortira prochainement de l'hôpital (leur ton indique en même temps combien ils en doutent), les hôpitaux étant si tristes et si déprimants. Enfin si le malade a besoin de quelque chose, peu importe quoi, il n'a qu'à le dire.

Ce visiteur-là parti, l'infirmière qui entre dans la chambre ne s'étonne pas de trouver son client prenant son pouls ou essayant de se regarder dans un miroir. Le pauvre croit avoir eu une

**Notes de Cours sur l'Administration hospitaliere, S. Hermine, f.c.s.p.*

rechute, tant il se sent plus mal, et n'aura de cesse que son médicin soit venu.

Un autre visiteur difficile, c'est le *plaignard*, qui est à son meilleur, s'il se trouve là lors du repas. Il se plaint de la nourriture, de la manière dont elle est apprêtée, ne trouve pas bon que l'infirmière aide la malade à manger et n'est pas plus content si elle ne l'aide pas et surtout ne parvient à comprendre que personne (et encore moins un malade) puisse manger la nourriture placée sur le plateau. Il sait sans même s'en être enquis, que la café est à peine tiède et que le dessert moins froid. Les assiettes de papier peuvent coûter moins cher, mais ce n'est pas lui qui mangerait là-dedans. Ce qui le surprend, c'est qu'on ait donné de l'eau froide. L'infirmière a dû se tromper et le malade en souffrira. Il s'aperçoit qu'il y a de la poussière sous le lit et un petit trou dans la couverture. D'après lui, on continuera de négliger et de maltraiter le malade à moins que ce dernier ne réclame ses droits, et il lui suggère de se plaindre à l'Hospitalière et de se décider à exiger les soins auxquels il a droit. A son départ, le dernier mot qu'il décoche est inévitablement celui-ci: "Ils vont exiger un gros montant de toi quand tu t'en iras, alors il vaut mieux qu'ils sachent que tu as l'intention d'être bien servi le temps que tu es ici."

Une visite de ce genre peut modifier entièrement une attitude; le malade satisfait, amical et qui autrefois faisait des progrès, on le trouve maintenant soupçonneux, mécontent et indisposé. Son état physique change en même temps que son attitude et le médecin traitant lit au dossier que son client n'est pas bien.

La visiteuse *timide*, elle d'ordinaire, si elle n'est guère dangereuse, peut ennuyer le malade énormément. C'est une petite femme à mine de souris qui ose à peine envisager qui que ce soit. Des internes dont elle a peur, elle n'entrevoit à la dérobée que des bas de jambes de pantalons blancs et une paire de chaussures blanches. Elle se glisse tranquillement dans la chambre, refuse de s'asseoir, même pour une minute, se sentant plus en sûreté debout, murmure plutôt qu'elle ne parle, répond par un sourire nerveux aux paroles de la malade qu'elle n'entend pas, tressaute à chaque fois qu'il passe quelqu'un dans le corridor. Elle ne quitte pas la porte des yeux, comme si elle s'attendait à ce qu'un être épouvantable se présente. Elle est certaine que les chambres voisines regorgent de personnes qui saignent et souffrent horriblement, et plus elle s'attarde, plus elle est mal à l'aise. Puis elle explique qu'elle s'évanouit à la vue du sang et qu'elle s'attend d'en voir, puisqu'il faut prendre les hôpitaux comme ils sont. Elle se sent soulagée de se sauver saine et sauve de l'hôpital, mais l'hospitalisé qui la voit partir l'est encore bien plus. Trop craintive pour se servir de l'ascenseur elle descend enfin l'escalier en s'arrêtant sans cesse, comme si elle marchait sur des coquilles d'oeufs.

L'un des pires tourments qu'un malade puisse se voir forcé d'endurer, c'est une séance avec la visiteuse qui *elle aussi, a eu cela* et qui est si difficile à supporter. Elle parle tellement de son opération que le malade n'arrive pas à parler de la sienne. Elle sait exactement tout ce qu'il souffre. Vous ne pouvez lui apprendre la moindre chose sur ce genre d'opération (vous n'avez d'ailleurs pas l'intention de le faire). Quant à elle, elle se souvient de la sienne comme si elle datait de la veille. Pensez donc, elle avait failli mourir sur la table d'opération et a tant souffert par la suite qu'elle aurait souhaité y être restée. Elle ressentait des douleurs indicibles, ne pouvait ni manger ni dormir, la morphine même ne la soulageait pas. Et elle criait à fendre l'âme si l'infirmière touchait à son lit. Peu importe le nombre de points de suture que l'on vous ait fait, cette femme en a toujours eu cinq de plus que vous! Et puis, le pire n'est survenu qu'après sa sortie de l'hôpital. On n'est jamais sûr de son affaire. Une hémorragie ou une embolie se produisent au moment où vous croyez que tout va pour le mieux. Sa voisine à l'hôpital X, qui avait subi la même opération qu'eux, n'est-elle pas morte d'une embolie deux semaines après son retour à la maison. Et elle lui conseille bénévolement de ne pas se rassurer quant à son état avant un an ou deux.

L'un des plus nuisibles visiteurs, c'est le *curieux* que l'on pourrait même appeler "senteux" sans faire un grand effort d'imagination. Ce visiteur-là pose des questions comme une mitrailleuse crache des balles, et au même rythme. A le voir entrer, on prévoit le genre de conversation qu'il tiendra. Il a un pas agressif et l'air de toujours réclamer des explications; dès son arrivée le malade se voit aux prises avec toutes ces questions: Pourquoi ne m'as-tu pas averti plus tôt? . . . Les infirmières n'ont pas voulu s'en charger? . . . Pourquoi te fais-tu traiter par le docteur Beauregard plutôt que par le docteur Brindamour? . . . Pourquoi as-tu choisi cet hôpital-ci, qui est plus éloigné de chez-toi? . . . Comment de temps comptes-tu y rester? . . . Est-ce qu'on t'a fait radiographié? . . . As-tu confiance aux médicins et aux infirmières? . . . Et pourquoi? . . . De quoi souffre le type de la chambre d'en face? . . . Et il ne peut se décider à partir sans demander: Combien ta chambre te coute-t-elle? . . . Est-ce vrai que l'hôpital a de la peine à rejoindre les deux bouts? . . . Ces visiteurs possèdent souvent les caractéristiques de l'amateur de scandales, le pire type de touts la gent visiteuse.

C'est ainsi que Mme "l'enquêteuse" par exemple, une fois qu'elle a vu la malade, ne manque pas de questionner les infirmières sur son état, son diagnostic et les traitements qu'elle reçoit. D'ordinaire, elle s'adressera à une infirmière encore aux études dont elle essaiera d'obtenir les renseignements désirés. Mais les étudiantes, à qui l'on a dit quoi faire en pareil cas, renverront Mme "l'enquêteuse" à la responsable de l'étage, comme il se doit. C'est alors que notre dame empruntera son air le plus aimable, son plus beau ton confidentiel, se dira l'amie la plus chère "de la pauvre femme du 388" et voudra tout savoir de son état, et cetera. Elle dira à l'infirmière: "C'est bien entendu, ma chère, qu'il s'agit de bien autre chose que de l'appendicite dont parlent les journaux et à laquelle croient les gens qui ne sont pas au fait comme nous le sommes, vous et moi. Je sais, depuis longtemps que cette chère Suzanne, quoi qu'elle prétende, ne passait pas toutes ses soirées à la bibliothèque publique." Bien entendu, ses soupçons ne datent pas d'hier. Qu'est-ce que les médecins ont trouvé? L'infirmière peut être sûre qu'elle ne soufflera mot.

Sur quoi l'infirmière déclare, que seul le docteur peut fournir un renseignement au sujet des malades. Et Mme "l'enquêteuse" s'éloigne furieuse, dans un nuage de poussière, convaincue qu'on lui cache quelque chose et que les infirmières ne veulent pas se compromettre.

Il est même arrivé que les plus acharnées de ces enquêteuses aient offert de l'argent pour payer des renseignements, lorsqu'elles entrevoyaient matière à un bon gros scandale.

Maison Montcalm,
Oldest House in Quebec City.

La visite bienfaisants

Tous les visiteurs n'appartiennent pas heureusement aux catégories que nous avons décrites. Il en est au contraire, dont le malade désire la présence. Peut-être sont-ils rares, mais ils existent.

Ces visiteurs se présentent à une

(Suite en page 72)

Resolutions

Adopted at Quebec by the

Canadian Hospital Council

Appreciation and Congratulations

1. International Hospital Federation

WHEREAS the Canadian Hospital Council is of the opinion that many problems of hospital administration are international in their scope; and

WHEREAS such problems can be dealt with most effectively by an international organization; and

WHEREAS international understanding can be fostered best by the convocation of international delegates;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council cable a message of congratulations and best wishes to the International Hospital Federation on the occasion of its initial meeting at Groningen.

2. Sun Life Assurance Company of Canada

WHEREAS the Sun Life Assurance Company of Canada has made very generous contributions to the support of the Canadian Hospital Council in the past and is still continuing to do so;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council express its sincere thanks to the Sun Life Assurance Company of Canada for its support.

3. Chateau Frontenac

WHEREAS our hosts, the management and staff of the Chateau Frontenac, have made every effort to provide service to the delegates assembled at this meeting of the Canadian Hospital Council; and

WHEREAS the delegates have enjoyed the hospitality of the Chateau Frontenac for the past few days;

THEREFORE BE IT RESOLVED that a letter of appreciation be sent to the management of the Chateau Frontenac.

4. MacLaren Advertising Company

WHEREAS the MacLaren Advertising Company has been most helpful in the matter of advising the Canadian Hospital Council regarding publicity and public relations generally; and

WHEREAS the MacLaren Advertising Company has through its connections with the press provided very valuable publicity for Canadian hospitals; and

WHEREAS the MacLaren Advertising Company has sent representatives to this and other meetings of the Executive of the Canadian Hospital Council; and

WHEREAS the above-noted services have been provided gratuitously by the MacLaren Advertising Company;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council express its appreciation of all these services to the MacLaren Advertising Company.

5. Press

WHEREAS the press of Canada in general has been very helpful in presenting the viewpoint of the hospitals of Canada to its readers; and

WHEREAS the press of the City of Quebec has given this meeting of the Canadian Hospital Council favourable publicity;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council express its appreciation, for the above-noted services, to the press of Canada in general and the press of the City of Quebec in particular.

6. Hospitality

(a) WHEREAS the local hospital authorities and the medical profession in the City of Quebec have provided deeply appreciated tours to historical points of interest and other forms of educational entertainment;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council go on record as expressing its appreciation of the hospitality shown by the local hospital authorities and the medical profession of the City of Quebec.

(b) BE IT RESOLVED that the Sisters in attendance at the Council meeting express their appreciation of the courtesy shown them by the Quebec Hospital Service Association in providing for them hospitality and a delightful sight-seeing drive about the City.

7. Canadian Dietetic Association

WHEREAS the Canadian Dietetic Association has provided a valuable service in maintaining and editing the Dietetic section in the *Canadian Hospital;*

THEREFORE BE IT RESOLVED that the Canadian Hospital Council express its appreciation of the assistance provided by the Canadian Dietetic Association.

Federal Government and the Hospitals

8. National Health Program

WHEREAS the Department of National Health and Welfare has established a plan for a very progressive and constructive National Health Program; and

WHEREAS the Department of National Health and Welfare has proceeded to implement this plan;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council commend the Department of National Health and Welfare for its National Health Program.

9. National Survey of Nursing Needs

WHEREAS the National Health Program provides grants in aid of hospital construction; and

WHEREAS the National Health Program visualizes a very material increase in the number of hospital beds in Canada; and

WHEREAS the presently existing supply of adequately trained nurses cannot meet the presently existing hospital nursing requirements; and

WHEREAS the studies regarding nursing services and nursing requirements presently being carried out by provincial "Survey Committees" serve the purpose of revealing some

of the problems of nursing services and related considerations at the provincial level; and

WHEREAS there has been delay in proceeding with a survey of nursing services and related considerations at the national level;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council express its regrets at the delay in the establishment of a national survey committee on nursing services, and further that the Canadian Hospital Council urge that the Department of National Health and Welfare set up a national committee on nursing services, which committee shall act as a national co-ordinating committee to assist the provincial survey groups in their studies and also to co-ordinate certain of the provincial recommendations into a national report.

10. The National Consultative Committee

WHEREAS, in the opinion of the Canadian Hospital Council, the best interests of the national health are served by the establishment of Consultative Committees representing the various provincial and federal organizations providing preventive and curative health services; and

WHEREAS the Minister of National Health and Welfare has established a National Consultative Committee with respect to the National Health Program;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council express its commendation of the Minister's policy in establishing the National Consultative Committee.

11. Correlation of Provincial Health Surveys

WHEREAS Provincial Health Survey Committees have under advisement the matter of hospitalization and/or custodial care of patients suffering from certain types of chronic ailments; and

WHEREAS Provincial Health Survey committees presently have under consideration the classification of certain types of hospitals designed for the continued treatment of chronically ill patients; and

WHEREAS Provincial Health Survey Committees presently have under consideration the matter of how best the chronically ill may be allotted to various types of hospitals, and further how the work of general hospitals may be correlated with special hospitals; and

WHEREAS in the interests of effective national administration it would appear to be desirable that an overall plan designed to secure uniformity of definition and classification be established throughout Canada;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council go on record as favouring the establishment of a Federal Correlating Health Study Committee which committee shall act as a liaison committee for the co-ordination of the work of the various Provincial Health Survey Committees.

12. Broader Construction Grants

WHEREAS the Federal Government has established the policy of providing grants in aid of hospital construction; and

WHEREAS such construction grants will aid materially in the provision of much needed additional hospital accommodation for patients; and

WHEREAS such additional patient accommodation will require additional hospital staff, professional and otherwise; and

WHEREAS hospital boards and local authorities are reluctant to extend their patient accommodation unless they can arrange for the housing of increased nursing and other personnel;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council request the Minister of National Health and Welfare to extend the scope of hospital construction grants to cover part of the cost of construction of nurses' residences and other essential and supporting services, and furthermore be it resolved that construction grants apply to all new construction regardless of net gain where it can be shown that an existing structure is obsolete for efficient patient care.

13. Care of Indians

WHEREAS certain departments of the Federal Government have endorsed the principle of paying for basic ward services and auxiliary hospital services at the prevailing rates currently charged by the various hospitals in the Dominion of Canada; and

WHEREAS the Federal Government has assumed responsibility for the

(Continued on page 64)

A.C.S. Workshop Conference at Edmonton

Leaders who assisted Dr. Malcolm T. MacEachern in the "workshop" or study conference held by the American College of Surgeons at Edmonton in April were: Dr. Angus McGugan, Edmonton (seated); Dr. Harry Coppinger, Winnipeg (left); Mr. George Masters, Vancouver; and Dr. Donald Easton, Edmonton. Several who were present agreed that the meeting provided greater returns for the time spent than any similar event attended.

Accounts DO Count

A Review of Four Hospital Accounting Institutes Held in Saskatchewan

R. M. Clements, C.A.,
Regina, Sask.

USING the assistance made available to Saskatchewan under the Dominion Professional Training Grant, four training institutes for hospital accountants were held in Regina and Saskatoon during February and March of this year.

The Saskatchewan Health Services Planning Commission, through its Division of Hospital Planning and Administration, desired to increase the accuracy and uniformity of hospital accounting and statistical returns, which have been based on a uniform system of accounting since 1947. The efficiency of the province's prepayment plan for hospital care depends, in large measure, upon the promptness and accuracy with which monthly and yearly information is supplied by individual hospitals.

Each of the four institutes followed exactly the same program, starting on Monday afternoon and finishing at noon on Friday. Travelling expenses and a per diem living allowance were paid for one candidate from each hospital and this procedure attracted large numbers of students. A total of 91 hospitals sent 125 representatives for training.

Before the first institute was held, accounting personnel of the Health Services Planning Commission devoted six weeks to careful organization and preparation. All hospitals in the province were circularized. Available accommodation in both cities was surveyed to determine which space met the minimum requirements for tables and chairs, adequate lighting, cloak room facilities, and accessibility.

Instruction at each institute was handled by five departmental accountants. Following registration, the institute opened with a review of the chapters of our *Hospital Accounting Manual* to prepare the class for a practical accounting problem.

The accounting problem proved to be the highlight of each institute. Each candidate was supplied with a separate set of forms from which to make up the financial statements of "XYZ" hospital for the month of January. These forms included admission and discharge records, charge memoranda for special services, invoices from suppliers, the monthly payroll, duplicate copies of cash receipts, duplicate bank deposit slips, cheque stubs from cheques issued, summary of the petty cash record, paid cheques returned by the bank, miscellaneous journal entries and adjustments. A balance sheet at the first of the month was included and each student was required to make the monthly entries in the hospital synoptic journal, to post the general ledger and subsidiary ledgers, and at the end of the month to balance the general ledger, reconcile the bank account, balance the subsidiary ledgers, and prepare the financial statement for the month. During the practice problem, accountants circulated among the students, answering their questions and lending a helping hand where necessary. On Thursday morning the accounting problem was discussed and reviewed.

Interspersed among the subjects on the program were special papers on laundry, drug and food costs, cost accounting, preparation and use of hospital budgets, hospital accounts during organization and construction, and statistical records and reports. Moreover, special presentations and discussions were held on personnel selection and classification and on provincial labour legislation affecting hospitals. Ample time was provided for questions and many valuable suggestions were made by the students. At the end of the institute certificates were presented to students who had attended all sessions.

Immediately following each institute, the work of every student was discussed and students were graded in order that those requiring further assistance could be aided by visits of the accountants to the individual hospitals throughout the summer months.

Although this training program offered a heavy week to each student, at no time was there a noticeable lack of interest or co-operation. The many favourable comments received have encouraged the Commission to organize further training programs for other hospital personnel in the coming months.

Mr. Clements is Chief Inspecting Accountant, Division of Hospital Planning and Administration, Sask. Health Services Planning Commission.

Quebec Conferences Hold Institute

The Montreal and Quebec Conferences of the Catholic Hospital Council of Canada are again this year sponsoring a short course in hospital administration which commenced May 9th and continues until June 26th. The first session was held in Quebec City from May 9th to May 23rd; the second session in Montreal from May 27th to June 10th; and the third is being held, also in Montreal, from June 10th to June 26th.

The course is under the patronage of Laval University and the University of Montreal in co-operation with the College of Surgeons of the Province of Quebec, the American College of Surgeons, and the American College of Hospital Administrators.

Over two hundred and fifty students registered for the course which is now open to laymen as well as as religious. Several professions—doctors, nurses, administrators, et cetera—are represented among the registrants. This year special attention is being given to dietetics and medical records.

Members of the faculty include some of the outstanding administrators and medical men of the province, and there are registrants from New Brunswick in the east and British Columbia in the west.

The Hobby Corner

12. Desmond T. Burke, M.D., C.M.

IN many instances, a man's hobby springs from his everyday work, suggested perhaps by his profession and providing diversion and recreation. In the case of Dr. Desmond T. Burke, director of the Department of Radiology at Sunnybrook Hospital (D.V.A.), Toronto, his hobby was well developed before he had even selected his college course. He tells us that at the age of 16, during a period of enforced idleness following empyema, he became seriously interested in rifle shooting and target practice. Three years later, in 1924, he achieved a place on the Canadian rifle team to Bisley (England) and startled veteran marksmen the world over by winning the coveted King's Gold Medal. Not only was he the youngest competitor ever to capture the trophy but he was the only one to win the first and final stages in the same year. At Bisley from 1924 to 1932, he won most of the major prizes, including the Prince of Wales, the Grand Aggregate, the All-Comers Aggregate, and was runner-up for the King's Medal in '27, '28, and '29.

In Canada he has established a record unique in the chronicles of rifle shooting by winning, in addition to most of the major prizes at the Provincial meet in Toronto, the King's Medal for the Canadian Army Championship eight times between the years 1925 and 1947.

Dr. Burke's hobby is not confined to accumulating an imposing array of trophies; the Canadian expert is author of a book on marksmanship, *The Practical Rifleman's Guide*, and has contributed articles on scientific aspects of rifle shooting to Canadian and British publications.

Major Desmond Burke at the annual meet of the Dominion of Canada Rifle Association at Connaught Ranges near Ottawa, 1947.

Despite the demands made upon his time by his radiological practice and his keen interest in improving the standards of training for x-ray technicians, Dr. Burke has been able to participate actively in Provincial and Dominion rifle shooting contests, holding executive positions on these associations. Last summer, at the Dominion meet in Ottawa, he won a place on the Canadian rifle team to Bisley in 1949. A rifle club was organized at Sunnybrook Hospital last year and Dr. Burke is looking forward to a larger membership and increased activity this summer.

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25 Years Ago

June, 1927

The Ford Hospital, Detroit, was being criticized for being too well run financially. Doctors were boycotting it; "Efficiency run rampant may be the worst inhumanity to man". The big hospital was nothing but a human garage. There was a pay-as-you-enter policy, with no credit extended to anyone. Everybody paid the same, regardless of circumstances. Only staff doctors could do surgery, and nurses and doctors worked on strict schedules, punching time clocks.

New hospitals were being erected at Englehart and Tillsonburg, Ont. •

Food and Its Service

Sponsored by the Canadian Dietetic Association

Consultation Services for Small Hospitals

Helen Sackville,
Nutritionist, Nutritional Division, Dept. of National Health and Welfare, Ottawa.

REQUESTS for dietary consultation services are becoming more numerous and urgent because of the scarcity of dietitians for small institutions and the difficulties encountered by busy superintendents in adequately supervising the food service.

Several provinces in Canada have undertaken this type of service in conjunction with their nutrition program. The role of the federal nutrition division has been, upon request of a provincial department of health, to survey the situation, determine the most pressing needs, and make general recommendations to that province as to the ways in which help can be given. To date, this type of assistance has been given in Alberta, Saskatchewan, Manitoba, and Nova Scotia.

Method of Survey

The general aim of the surveys is to arrive at an estimate of the nutritional quality of the diet. At the same time, observations are made of all other factors relating to the food service. Sufficient time is spent in each institution to observe the preparation of at least one meal in the kitchen, noting the equipment used and the cooking methods employed. The food is then followed to the service areas and observations made on the attractiveness and palatability of the food as served, the appearance of the trays, and the dishwashing methods. A discussion is held with the superintendent to discover her interest in providing good food service and any problems she may have encountered.

The first assistance was given in Manitoba, in 1946, when twenty-six small hospitals were surveyed. Since then several representative types of small hospitals have been visited in Alberta to ascertain what help would be most acceptable.

In Saskatchewan, two mental hospitals and a training school for defectives were assisted in establishing a standardized scale of food issue for the three institutions.

Fifty-six institutions of various types were surveyed in Nova Scotia. These include: general hospitals serving both public and private patients; tuberculosis hospitals; mental institutions; benevolent institutions for the aged and poor; homes for normal, delinquent, and defective children.

On the completion of the visit, standard inspection forms are filled out giving details of all phases of the food purchasing, storage, preparation, distribution, tray and dining-room service, special diets, dishwashing, equipment, employees, general cleanliness, garbage disposal, et cetera. Comments and suggestions are then made for improving the food service, and these are attached to the inspection form. Several copies of these inspection reports are submitted to the province in question so that there is always one available for the individual institution. The superintendents can study these reports, learn their own rating, and submit them to the board of directors for its consideration. Recommendations from an outside source are often effective in bringing about changes where it has previously been difficult to achieve them.

The follow-up of the survey and the carrying out of recommendations concerning further help is left entirely in the hands of the province concerned.

Most frequent requests from superintendents and cooks were for help in menu planning and supper suggestions.

Survey Observations

As for the needs as seen from the results of the surveys, these were numerous and varied. Obviously these needs were often not realized by the institution. Those most common to all institutions were for:

(a) Nutritional improvement of the menus by increasing the protein content; the use of more citrus fruit, citrus juice or tomatoes; and the use of more whole grain cereals and whole grain bread;

(b) Aesthetic improvement of the menus by the use of crisp foods with bland meals, more varied use of available foods, and wider use of garnishes;

(c) Improved cooking methods to eliminate dry meat and fish, overcooked vegetables, and lukewarm beverages;

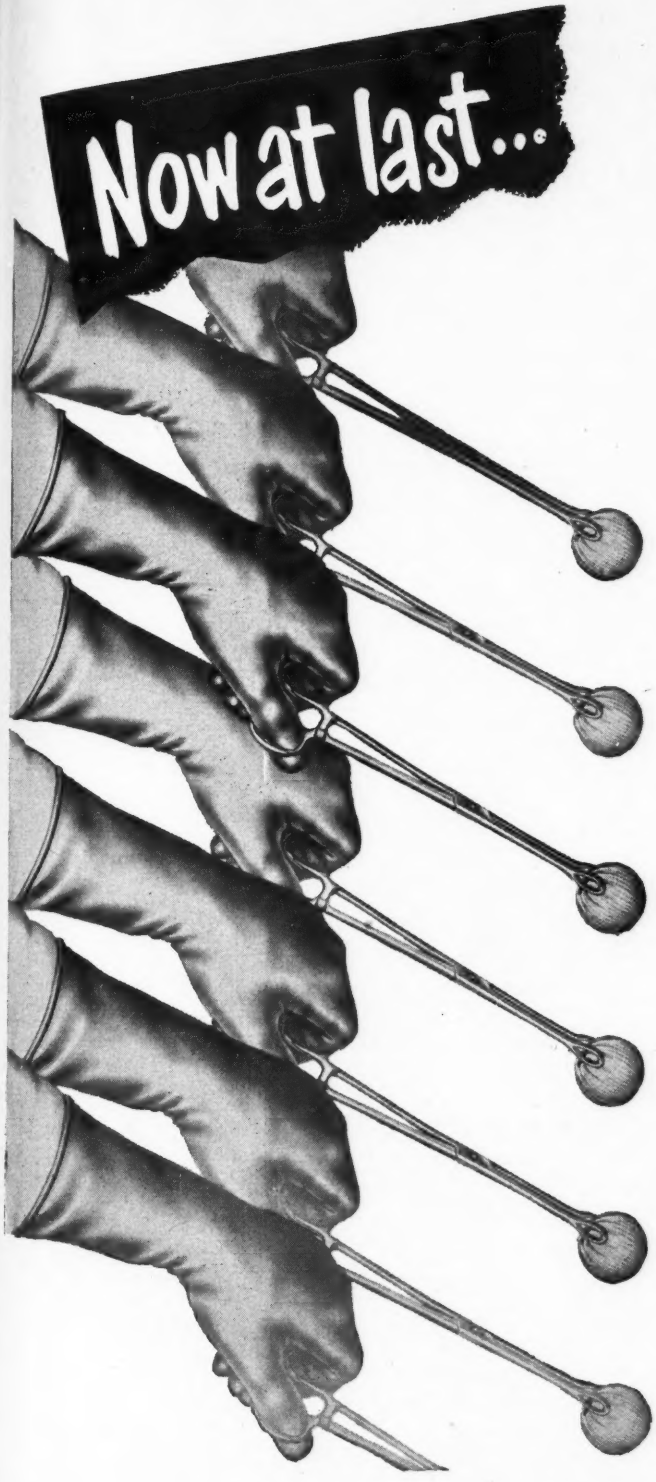
(d) Suggestions for improving the appearance of the trays, such as the type of dishes, type of tray cover, size of serving, method of serving, temperature of food, preheating of the dishes, et cetera;

(e) Introduction of colour into many of the dining-rooms to relieve the drab, dreary atmosphere;

(f) Improved standards of cleanliness and sanitation by better facilities for hand washing, clean uniforms and hair nets for kitchen and dining-room employees, covered garbage cans, tidy store-rooms, and clean tea towels;

(g) Improved dishwashing methods because of almost complete lack of multiple compartment sinks.

One province having a strong desire to do something about the requests for help from their institutions, yet lacking sufficient staff to carry it out themselves, asked for assistance from the federal department. Subsequently a nutritionist spent considerable time in thirteen institutions giving help in any way possible, depending upon the particular requests



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The new **Curity Rondic** Sponges are ready-made round or "ball-shaped" sponges like those made by hand in most hospitals in the past. They are made of long-fibre cotton securely covered with fine mesh gauze, and are offered in four convenient sizes.

A "SPONGE-STICK" SPONGE. Rondic Sponges are suitable for use with "sponge-stick" or sponge forceps in any field of surgery. They have been used successfully in abdominal surgery, vaginal and rectal repair, etc. In any situation where a "sponge-stick" is used, **Rondic** Sponges are ready for use.

Other uses are myriad, in all departments. Some of them are:

Tonsil sponge and pack.
Prepping and painting.
Hypo, intravenous or hypodermoclysis wipe.
Any "sponge-stick" use on the floor, dressing carriages, in the laboratory, examining or emergency rooms.

SAVE VALUABLE NURSE-TIME. Rondic Sponges, the first ready-made balltype sponge, release nurses for vital professional duties. The advantages of other ready-made dressings (such as **Curity** Gauze Sponges, **Lisco*** Sponges and **Radiopaque*** Sponges) are known to all hospitals. Now the same advantages may be enjoyed on round sponges.

Ask your **Curity** representative to demonstrate the new **Rondic** Sponges.

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and upon the needs as learned from the previous visit.

For example: Suggestions were made for improving the menus.

In those institutions producing large amounts of vegetables, suggestions were made for serving them in a variety of ways.

Suggestions were made for ways of improving the appearance of the trays.

Substitutions for foods in certain special diets were listed.

Since Christmas was approaching, suggestions for Christmas tray favours were left with the superintendents.

Recommendations were made for the most urgently needed equipment.

Recommendations were made for improving cleanliness and sanitation.

The best method of dishwashing possible under the circumstances was outlined.

Work schedules for employees were drafted.

To facilitate the carrying out of the suggestions made, the following materials were prepared and left with the institutions:

(a) A guide for menu planning. This is based on Canada's "Food Rules" with special emphasis on high protein for hospital menus.

(b) Large quantity recipes. Special attention is paid to low cost supper dishes since these are mentioned frequently in requests. The large quantity recipes were well received because many institutions were building up their large recipes from the household size.

(c) Cleaning procedure cards. These typed cards outline recommended methods for the cleaning and care of fixed and small equipment, floors, walls, et cetera, for use in training employees.

Help was gratefully received by superintendents and cooks alike. In most cases they fully realize the important part that good food and attractive service plays in the recovery and well being of the patient, and consequently in the reputation that the institution builds for itself in the community.

Dr. Joe Clemmons Dies

Dr. Joe Rainey Clemmons, medical director and executive vice-president of Roosevelt Hospital, New York, until his retirement on January 1, died on April 2 at the age of 52. During the last war, Dr. Clemmons headed the state's procurement and assignment service in securing physicians for the armed forces and his work was recognized by citations from President Truman and the Surgeons General of the Army, Navy, and Public Health Service. Dr. Clemmons was a valued member of the A.H.A., the A.M.A., and a Fellow of the A.C.H.A.

Catholic Hospitals of Quebec to Hold Annual Convention

The Catholic Hospitals of the province of Quebec will hold their annual convention in Montreal, June 27-29, following the seven weeks' course in hospital administration at Quebec City and Montreal. Some 3000 registrants are expected to attend the meeting, coming from all parts of Canada, and many outstanding speakers from both Canada and the United States will be present. The general theme for the convention is, "The Hospital, a Service to the Patient".

The above group of dietetic interns (Toronto General Hospital, 1949), numbering twenty-one is the largest class of dietitians ever graduated from any Canadian hospital.

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With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

The discussion which has been taking place about the blood transfusion service in Canada suggests to me that it might be of some interest to give an account of the developments in Britain.

The first growth of the service was due very largely to the enthusiasm of a man named Oliver, who was an official of the Camberwell Borough Council and devoted his spare time to the local branch of the British Red Cross Society. In 1921 four members of the branch gave their blood in response to a call from a local hospital. From that beginning was established a day and night service. When Oliver was at the office, his wife was available to take the calls and arrange to obtain the volunteer whose turn it was on the rota. In a memorandum recently issued by the Ministry of Health it is claimed that from this beginning grew "the first blood transfusion service in the world".

Now there is a National Blood Transfusion Service administered by the twelve Regional Boards under the National Health Service. Each region is centred in a university town where an organization is maintained for collecting blood within the region. When an appeal is made in these areas by press and radio, donors attend "bleeding sessions" where each person gives just under a pint of blood. The blood is placed in a refrigerator and taken to the regional blood transfusion laboratory, for grouping and testing, from which the hospitals draw their supplies.

Each of the principal hospitals maintains a supply of blood, sufficient not only for its own needs but also for the smaller hospitals, nursing homes, and general practitioners in its district. This supply is replenished from the regional blood bank every week, or more often as the necessity arises. In this way, it is ensured that no one who needs a transfusion will have to go without, even if the patient lives in a remote country district.

The use of blood transfusions was greatly developed during the war and has continued to increase. More blood was used in hospitals in England and Wales in 1948 than in 1944 — D-Day year. In 1948, 393,301 donations were made as compared with 294,556 in 1947, an increase of about 100,000. The demands of the hospitals are rising every month; a special appeal has been put forward in order to keep pace with them. The appeal is confined to those between the ages of 18 and 65 and addressed specially to the younger generation. In 1944 there were 1,005,000 donors enrolled on the regional panels. The number dropped to 270,000 by the end of December, 1946. Since then there has been a growing appreciation of the fact that blood transfusion has an important role in peace time, and there are now over 370,000 donors in England and Wales. The addition of 100,000 donors in the two years has not, however, satisfied the increasing demands on the service, which, in order to reduce calls on the individual donor to a minimum of one every six months and to provide for the future expansion of the service, has a target of another 200,000 donors, or a total of nearly 600,000.

National Blood Transfusion Service

The difficulty which has arisen in Canada has not been experienced in this country, as far as I am aware, and cannot now develop under the National Health Service. If a person is a private patient, paying full charges for accommodation and for medical fees, the pathologist may feel inclined to charge for his services. I remember an occasion in the early days when the point was raised and I rather discouraged the idea. To the patient, the donor is the one important person and the service rendered by the pathologist in inserting the blood is quite a secondary consideration. There have been occasions when the patient has wished to make a gift to the donor, but the tradition of the service has always been against it, just as nurses never receive gifts. For the ordinary person in hospital, blood transfusion is available without charge as is any other service.

Postscript on Medical Stamps

As *The Canadian Hospital* has shown an interest from time to time in postage stamps, perhaps some of your readers may be glad to know of a little volume, recently published, which contains a record of "Medicine and Science in Postage Stamps". It is by Mr. W. J. Bishop, librarian of the Wellcome Historical Medical Museum and Mr. N. M. Matheson, F.R.C.S., and is published by Harvey and Blythe, 6 Hanover Square, London W., 7/6.

Although the record does not pretend to be comprehensive the number and variety are quite remarkable. The main sources are the Red Cross and Tuberculosis stamps and the commemorative and anniversary sets which have been issued in recent years. An intriguing aspect of the subject is to detect the "truants", as Lord Moynihan called them, that is, the men who qualified in medicine and deserted it for some other walk of life in which they became famous.

The commemoration of medicine goes back to the witch doctor and from Greek mythology covers the whole range of medical history to recent years when the interest in public health rather than the cure of disease is being illustrated in stamps. The attractiveness of this volume is enhanced by thirty-two pages of illustrations containing many stamps.

With the Auxiliaries

Aids Participate in National Hospital Day Programs

One of the greatest contributions of women to the cause of humanity was remembered on May 12th when many hospitals throughout Canada observed National Hospital Day on the anniversary of the birth of Florence Nightingale. Out west, in Vancouver, Shaughnessy (D.V.A.) Hospital threw open its doors to more than 500 visitors. Hospitals in Ontario were particularly active. At Clinton the event was celebrated by the official dedication and opening of the new $140,000 24-bed wing; citizens of Oshawa were welcomed to inspect the facilities and equipment of their general hospital. Hundreds of London residents were attracted to "open house" at Victoria, St. Joseph's, the War Memorial Children's, Westminster Veteran's, and Parkwood Hospitals. The women's auxiliaries of these hospitals were kept busy serving tea to the guests.

National Hospital Day was not observed at the Chatham Public General Hospital in the usual "open house" manner, due to overcrowded conditions. However, a host of varied activities were planned. Two teas, sponsored by the Ladies' Assisting Society of the hospital and by the Heather Society, attracted many guests and prospective students of nursing. "Girls in White", an R.K.O. film, was shown for four days in the local theatre. On May 12th a dinner was given to honour the nursing school and the 100 guests included board members, hospital department heads, members of the 1949 graduating class, and heads of the ladies' hospital aid societies. The feature of that evening was an address, entitled "The Power of Personality in the Life and Work of the Nurse", by Mary Morgan, noted beauty and fashion expert. On Sunday, May 15th, special Florence Nightingale Memorial services were held throughout the community; in the morning members of the local branches of the ladies' hospital aids attended Chatham Baptist Church and a body of 100 nurses, including the graduating class, were present at the evening service in Victoria Avenue United Church.

Conducted Tours and Auxiliary Spring Tea Mark National Hospital Day at Women's College Hospital

Observance of National Hospital Day, May 12th, was a successful and well-planned event at the Women's College Hospital in Toronto. Conducted tours were arranged for guests attending the Spring tea held by the women's auxiliary in the nurses' residence, and these tours included such departments as the dietary, emergency, nursery, and operating rooms. The auxiliary has purchased many items of equipment for the hospital as well as being responsible for a travelling tuck shop and the most recent addition, a portable magazine rack. Proceeds from the tea, which attracted some 200 visitors, amounted to $180 and will be used for the purchase of more equipment.

Receiving guests at the tea were, left to right: Miss Dorothy Macham, superintendent of the hospital; Mrs. A. M. Huestis, past chairman of the board of directors; Mrs. G. B. Woods, a charter member of the auxiliary; Mrs. Peter Sandiford, chairman of the hospital board; and Mrs. T. J. Lytle, president of the auxiliary, and president-elect of the Women's Hospital Aids Association of Ontario.

* * * *

Windsor, (Ont.), Sponsors Successful Concert Series

The Auxiliary to Grace Hospital, Windsor, sponsored the most successful series of concerts in its history, realizing proceeds totalling $1,737.38. The auxiliary is undertaking to equip a new operating room at a cost of $5.000. Another major event of the year will be the annual garden party held in June.

* * * *

Montreal Aid Launches Drive for New Nurses' Residence

The Women's Auxiliary of the Jewish General Hospital has been assigned the task of furnishing and equipping the new nurses' school and residence which is being planned at the present time. In order to raise the necessary funds, a subscription campaign is being launched and the entire membership canvassed. This campaign will function on a "Give-or Get" basis; each woman must set as her goal a quota of $25, either to give or to get, and thus qualify for a Special Events Luncheon to be held early in October. To facilitate the task of raising $25, receipts for $1 subscriptions will be issued. An attractive prize will be offered to the individual worker raising the most money. Regular meetings of captains and control chairmen will be held to keep interest at a peak and to encourage workers to reach their goal.

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Small and Large Hospitals

(Continued from page 30)

various methods of improving hospital and medical care through a voluntary association of hospitals and their medical staffs. Although the Regional Council works within the confines of an 11-county region centring around Rochester, New York, it should not be considered as a local undertaking, primarily.

The Council of Rochester Regional Hospitals is not the only organization concerned with the special problems of small hospitals and medical care in small communities. The Bingham Associates Plan in Maine and Massachusetts covers some of the same ground, and plans centring around the Medical College of Virginia, University of Virginia, University of Colorado, Yale University, the University of Buffalo, New York University, and perhaps others as well, are concerned with improvement of care through resident rotation programs and post-graduate medical education.* The experience of the Commonwealth Fund with a group of 14 rural hospitals widely dispersed throughout the country led to the organization of the Council of Rochester Regional Hospitals to experiment in the solution of the problems of small hospitals. Unlike the plans just named and various hospital councils in this country, however, the Rochester Regional Council attempts to cover all three of the basic problems—facilities, specialized services, and education. The only aspect not covered is medical economics — hospitalization insurance, medical insurance, and the like.

The Regional Council has five *objectives*, with corresponding programs. They are:

1. A continuous educational program for physicians, dentists, nurses, and hospital personnel, with the emphasis on post-graduate study.

2. Advisory services in clinical and laboratory medicine, and in hospital administration.

3. Aid in planning for adequate facilities.

4. Development of such joint administrative services as are found desirable and practicable.

5. Observance of recognized standards in all departments of hospital organization and operation.

**Mention might have been made also of the fine, although somewhat different, program of the Kellogg Foundation in Michigan.—(Edit.)*

Organization

The Council is organized as a democratic working association of medical, hospital, and public interests. Its board of directors is made up of lay representatives from the boards of its 27 member hospitals, and a public representative from each of the 11 counties of the Region. There are two very important working groups, advisory to the board, but entirely free to explore, study, and recommend. They are: the Medical Conference, composed of the delegate and alternate from each medical staff; and the Administrators' Conference, composed of the hospital administrator and alternate. The board and the two conferences include 169 interested, active, articulate members who devise policies and carry out programs and activities through the paid executive staff.

The Regional Council's *advisory services in hospital administration* range from advice on how to handle the application of an osteopath for medical staff membership, to a full-scale hospital survey. Included in this program is cost analysis of schools of nursing, studies of costs and charges for various services and supplies, an annual nursing-hour study, advice on legal questions, and help in finding and correcting causes of hospital deficits, to name only a few.

Educational Activities

Medical Education. In medical education, about eight post-graduate courses of three to five full days are held each year, with an average attendance of 30 physicians, about two-thirds being from small communities.

Most of the larger hospitals provide, without charge, opportunity for general practitioners to spend one, two or more months working along with the resident staff in medicine, surgery, obstetrics, cardiology, and other fields. Each year 10 fellowships are awarded for short, formal courses in medical centres outside of the Rochester Region. Every month clinicians go out from Rochester, Buffalo, or other medical centres, to conduct teaching clinics in the smaller hospitals. Interns and residents rotate regularly from the larger hospitals to the four 100-bed hospitals in the Region, providing continuous resident service throughout the year.

Nursing Education. An average of six nurses per year receive fellowships for 4-month, full-time college-credit courses in nursing supervision and operating room technique. Educational meetings for nurses held every two months at various points in the Region attract a total attendance of about 400. A grant by the Council to the University of Rochester led to establishment of degree courses in nursing supervision, public health and industrial nursing. As a result of Council activities, it seems likely that the Region will establish a central school for student nurses, relieving hospitals of the necessity of providing education in the pre-clinical phases of nursing education. Rochester's School of Practical Nursing has had its enrolment increased, and the practical nurse students are now obtaining training in two of the general hospitals, whereas previously they were limited to chronic disease hospitals.

Hospital Administration Education. In 1947, 1948, and again this year, the Regional Council has conducted a college-credit course in hospital administration at the University of Rochester. Designed primarily to fill in the background of theory which many small-hospital administrators have missed because of advancement to their posts from nursing and other occupations, it has each year attracted from 18 to 20 administrators. The course is set up for 32 class hours of two 2-hour classes held every other week. Subjects are chosen which it is hoped will aid administrators in future planning; classes are rather informal and each one is followed by a discussion period. The faculty is drawn both from Rochester and other large centres in the East.

The Regional Council has conducted other courses of its own: for laboratory technicians prior to the opening of the Regional blood bank; for medical record librarians; for hospital accountants and

(Continued on page 90)

Notes on Federal Grants

Construction

Ottawa has approved grants to aid eight hospitals in Quebec, meeting construction and alteration costs increasing the number of beds by 832. The allotments are as follows: 300-bed Gaspe Sanatorium, $322,693; Notre Dame de Ste Croix Hospital, Mont Laurier, 75 beds, $75,000; Chandler Hospital, 56 beds, $56,000; Lake Edward Sanatorium, near Quebec City, providing 22 more beds, $5,300; Herbert Reddy Memorial Hospital, Westmount, gaining 20 beds, $20,000; St. Joseph's Hospital, La Tuque, adding 45 beds, $26,400; new hospital at Amos and enlarged existing one, totalling 215 beds, $189,400; St. Theresa's Hospital, Shawinigan Falls, increasing by 148 beds, $148,000.

The Ottawa General Hospital, Ottawa, will receive more than $145,000 in federal funds as a first instalment to assist in its plans for expansion. This grant applies to the Youville wing only, where two floors will be added to provide about 145 extra beds. Eventually there will be an over-all increase of 230 beds and 74 bassinets.

Winchester and District Memorial Hospital, Winchester, Ont. is a new 32-bed institution, recently completed, and has been approved for a federal grant of over $15,300.

St. Mary's on the Lake, Kingston, previously the Kingston Military Hospital, is being converted to a hospital for chronically ill by the Sisters of Charity. It will receive a grant of approximately $33,700 from the federal government. Neither the Winchester hospital nor St. Mary's on the Lake receive the full amounts being granted per bed because construction had begun before the federal plan became effective.

In British Columbia, the largest single grant of a recently approved group is $147,000 for the new Mount St. Francis Infirmary, Nelson. When completed this institution will have 98 beds for the care of chronically ill and convalescent patients. It will be administered by the Sisters of St. Ann.

The Provincial Mental Hospital at Essondale will receive $83,000 to assist in increasing its bed capacity by 100 beds.

The Prince Rupert General Hospital, the capacity of which has been increased by 54 beds, will receive more than $6,300. The building is a former army hospital which has been altered to suit civilian needs and is eligible for partial assistance.

The Royal Jubilee Hospital, Victoria, will receive about $9,000 in federal aid to help cover the cost of renovating the Strathcona wing or children's ward. Nine extra beds have been provided.

Mental Health

More than $28,600 has been earmarked for new medical, surgical, and clinical equipment at the Ontario Hospitals in Brockville and Kingston. Also to be equipped is the travelling mental health clinic operating from Brockville which covers a large area in eastern Ontario, visiting Ottawa, Smith's Falls and Hawkesbury.

At the Ontario Hospital, London, clinical and occupational therapy facilities will be improved and extended with a grant from the federal government.

Ontario hospitals in Hamilton, Toronto, and New Toronto, will receive about $42,500 worth of new equipment, including clinical, surgical, x-ray, and teaching equipment.

Research

The University of Toronto will receive grants totalling more than $18,000 to finance two projects in public health research, to be carried out at the Banting Institute. One will be a study of the clinical uses of isotopes in the therapy of certain types of malignant disease, under the direction of Dr. J. A. Dauphinee, professor of pathological chemistry. The second will concern the study of hormones, their relation to disease in humans, and the application of this knowledge to clinical problems. It will be under the direction of Dr. A. G. Gornall, assistant professor of pathological chemistry. The funds provided by the federal government will be used to initiate these studies through the purchase of the special equipment required for them.

Tuberculosis

Approximately $200,000 has been set aside to assist the Bruchesi Institute and the Royal Edward Laurentian Hospital, Montreal, in their programs of tuberculosis control. Both operate a central clinic and branch clinics in various parts of the city to provide services including diagnosis, visiting nurse service, and laboratory facilities.

Health Grants for Newfoundland

The Hon. Paul Martin has announced that sums totalling nearly $1,000,000 annually have been earmarked for Newfoundland under provisions of the various health grants. It is expected that the funds for the new province will be distributed as follows: health survey, $19,779; hospital construction, $354,629; general public health grant, $132,400; tuberculosis control, $176,614; mental health, $122,171; venereal disease control, $15,944; professional training, $15,944; crippled children, $15,944; cancer control, $90,093.

The federal government is basing apportionment of the grants on the estimated Newfoundland population of 331,000 as of June 1, 1948, and is using the same method of calculating the amounts as is used in making grants to each of the other provinces.

Ontario Signs Agreement Under National Physical Fitness Act

Ontario has signed an agreement with the federal government under the terms of the National Physical Fitness Act, 1943. Each year the federal government allots $225,000 to the provinces to assist them in the development of recreational and fitness programs. This amount is divided on a per capita basis and Ontario's maximum share will be $74,063.25. All provinces except Quebec and Newfoundland now have agreements with Ottawa under the National Physical Fitness Act.

Health Program

(Continued from page 32)

are to be matched by provincial expenditures. Thus the expenditure of these large sums of money will be reflected in new public health services in the next few years. The second condition is that, although the grants are generally on a population basis, an adjustment has been made in the case of the smaller provinces by establishing a minimum grant.

Purposes of Grants

The grants may be regarded as falling into two groups. First, those to assist in providing additional public health service facilities, and in this category I would include the grants for health surveys, general public health, professional training, hospital construction, and public health research. In the second group are those directed at specific diseases or conditions, that is, the tuberculosis and venereal disease, mental health, cancer, and crippled children grants.

The Health Survey Grant, amounting to $644,779, is designed to assist the provinces in assessing their present facilities and arrangements, and deciding on ways and means of improving and extending their services and of determining priorities. All the provinces have submitted programs for the full use of this grant and surveys are now under way.

The General Public Health Grant, amounting to $5,276,000 is to assist the provinces in strengthening their general public health services. The grant is to be allocated on the basis of 35 cents per capita to be raised at the rate of five cents per year to 50 cents per capita. As examples of its use: one province is establishing a division of sanitary engineering; another, a division of dental hygiene; laboratory services are being extended to another province, and one province will use some of its grant for a health education program.

The Professional Training Grant, which is $515,944, is to assist the provinces in training public health and hospital staffs. Special training in public health will be provided for doctors, dentists, and graduate nurses. Graduate nurses are pursuing advanced courses in administration and supervision, others are taking training in nursing education and clinical supervision. As already mentioned, a real obstacle to rapid utilization of these funds is the shortage of trained people. Recognizing that this situation calls for heroic efforts, many provinces are using funds from some of the other grants for the special training of personnel to work in the fields toward which the grants are directed.

The Hospital Construction Grant, which is the largest one, amounts to $13,344,629 annually. This is an annual grant for five years and, unlike the others, it is cumulative. It is to assist in the provision of more beds, for which, as you well know, there is urgent need. Under the terms of the grant $1,000 is to be provided to assist in the construction of each active treatment bed and $1,500 for each chronic or convalescent bed, provided the province makes an equal grant. This is in line with the scheme in operation in Ontario. Many projects for assistance under this grant have already been approved. Hospitals are not erected in a day, and it will be some time before we can measure the effect of this grant.

A Public Health Research Grant of $100,000, which it is planned to increase by the same amount annually to a maximum of $500,000, is to assist the provinces in stimulating and developing public health research. The grant is to be available to the provinces jointly or individually. Projects will be approved by the Dominion Council of Health assisted by a technical reviewing committee. All of the funds proposed for the current year have been allocated to research projects. This program, of course, is additional to that of the National Research Council which is for *medical* rather than *public health* research; it does not in any way conflict with the growing research program of the National Cancer Institute. I should like to make this point very clear. The national health program is not intended to usurp functions already well established. The Canadian Cancer Society has undertaken to raise funds in aid of the Cancer Institute's program and must have public support. Careful arrangements have been made to ensure that there is no overlapping and needless duplication.

Turning now to grants for specific diseases, the first of these is the Tuberculosis Control Grant of $3,176,614 which may later be increased to more than $4,000,000. You are aware of the great strides that have already been made and of the great role played by voluntary agencies in this field. It is hoped that the extra stimulus which will follow this financial aid will assist in bringing this disease under control in Canada.

From a study of projects already approved it is evident that every avenue of attack is being followed, from the routine chest x-ray of all hospital admissions, which is being instituted in Ontario, to the free administration of streptomycin where needed.

As already mentioned the first health grant in 1919 was for venereal disease control. In recent years this grant has amounted to $225,000. Under the new national health grant program this amount has been increased to $515,944. This money is being used to increase detection and treatment facilities and to provide drugs.

The Mental Health Grant of $4,122,171, which may be increased to more than $7,000,000, is to assist in the prevention of mental illness. A major undertaking in this field is the initiation of a mental health training program at Canadian Universities for the preparation of psychiatrists, clinical psychologists, psychiatric social workers, psychiatric nurses, and other medical personnel. Also, teachers will be given instruction in various aspects of psychiatry in order that they may serve as liaison officers between the schools and psychiatric clinics. This is in line with the need already mentioned of concentrating in the early stages on the provision of trained people to staff the schemes yet to be developed. From some provinces have come projects for child guidance clinics, diagnostic clinics, and for the improvement of treatment facilities in mental hospitals.

In 1945, the proposals put forward at the Dominion-Provincial Conference did not include a specific grant for cancer. It was considered then that the general public health grant could be drawn upon for this purpose. Since then important advances have been made in the organization of special facilities for diagnosis and treatment. For this reason the pres-

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C.H.C. Resolutions

(Continued from page 45)

hospitalization of certain classes of citizens; and

WHEREAS the Indian Affairs Branch of the Department of National Health and Welfare has assumed responsibility for the hospitalization of Treaty Indians whose hospitalization is authorized by the Indian Affairs Branch; and

WHEREAS the Indian Affairs Branch of the Department of National Health and Welfare has not endorsed the principle of paying for basic ward and auxiliary hospital services at the prevailing rates currently charged by the various hospitals in the Dominion of Canada;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council request the Minister of National Health and Welfare to pay for basic ward and auxiliary hospital services on behalf of all patients hospitalized on authority of the Indian Affairs Branch at the prevailing rates currently charged by the various hospitals in the Dominion of Canada.

14. Hospitals and National Defence

WHEREAS the Minister of National Defence has provided for the establishment of the Canadian Medical Co-ordinating Committee to formulate plans for the co-ordination of civilian and military services in the event of a national emergency; and

WHEREAS the Canadian Hospital Council is desirous of collaborating in any manner possible in the co-ordination of civilian and military hospital services in the event of a national emergency;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council commend the action of the Minister of National Defence in establishing the Canadian Medical Co-ordinating Committee, and further that the Canadian Hospital Council assure the Minister of Defence of the full co-operation of the Canadian Hospital Council in any plan designed to provide adequate co-ordination of civilian and military hospital services in the event of a national emergency.

15. Training of Personnel

WHEREAS the Federal Government has provided a special grant for the training of hospital personnel; and

WHEREAS the Federal and Provincial plans for the provision of greatly increased hospital accommodation suggest that hospital personnel in greatly increased numbers will be required; and

WHEREAS the supply of trained hospital personnel, particularly registered nurses, hospital administrators, laboratory technicians, radiographical technicians, medical record librarians, hospital dietitians, and instructors for schools of nursing, is not sufficient to meet the presently existing demand;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council recommend to the Minister of National Health and Welfare that a conference or conferences between representatives of the Department of National Health and Welfare and the Canadian Hospital Council be held to determine how best the training of greater numbers of hospital personnel might be accomplished.

16. Practical Nurses

WHEREAS the Canadian Hospital Council appreciates all that has and is being done in the assistance of the education of practical nurses by the Dominion Government under its vocational training program; and

WHEREAS it is the present policy of the Dominion Government to confine its assistance to unemployed persons; and

WHEREAS the hospitals of Canada can use a much larger number of such trained personnel;

THEREFORE BE IT RESOLVED that the Dominion Government be requested to extend its assistance to all individuals who are desirous of taking advantage of such training.

Provincial and Municipal Relations

17. Recognition of Expenses

WHEREAS many public voluntary hospitals in Canada were originally constructed or later expanded as a consequence of donations from various sources, including Dominion, Provincial and Municipal Governments, other hospitals have found it necessary to borrow money, either wholly or partly, for construction purposes in such manner that the borrowings constitute a direct liability of private owners and operators; and

WHEREAS it is the accepted practice in industry to charge interest on borrowings for construction purposes as an expense payable from the operations of the industry for which the money was borrowed, either direct or, alternatively, to meet such interest from the profits of such industry and;

WHEREAS all public voluntary hospitals in Canada are operated without either profits or dividends, and therefore, while the government owned and operated hospitals can and do resort to taxation to meet this expense, the private operators have no means of meeting interest on borrowings other than as an operating expense; and

WHEREAS the interest in such cases is an actual expense of operating the hospital; and

WHEREAS the provinces operating compulsory hospital insurance plans have, up to the present time, declined to accept interest on construction borrowings as an expense of operating a hospital; and

WHEREAS the Canadian Hospital Council is of the opinion that the interest on such capital borrowings as are a direct liability of the operators of a privately owned public voluntary hospital is properly, and inevitably must be, a charge against the operations of such hospitals;

THEREFORE BE IT RESOLVED that the views of the Canadian Hospital Council expressed in the preamble to this resolution be communicated to all provincial governments through the Provincial Hospital Associations, and that the provincial governments which today operate compulsory hospital insurance plans be requested to accept such interest as an expense to be included in the calculations used to determine the rate to be paid to each hospital in respect of persons hospitalized under the provincial hospital insurance plan.

18. Payment by Governments and Municipalities

WHEREAS in all provinces in Canada there is statutory provision whereby Provincial and/or Municipal governments are required to provide hospital care for indigents; and

WHEREAS in some localities there is a tendency for governments to expect hospitals to provide hospital care for indigents on a sub-cost basis; and

WHEREAS hospitals are criticized for showing deficits which, not infrequently, result from assuming

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responsibilities which are governmental;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council endorse the principle of provincial and municipal bodies paying the currently existing basic ward hospital rates and the currently existing hospital schedules for extras on behalf of patients admitted on authority from provincial and municipal governments.

General

19. Red Cross Transfusion Policies

WHEREAS the Red Cross Society has established a blood transfusion service in some provinces in Canada: and

WHEREAS the Red Cross Society proposes to establish a blood transfusion service in other provinces in Canada; and

WHEREAS the operation of the Red Cross Transfusion Service is reported as operating to the satisfaction of the hospitals in some provinces in Canada; and

WHEREAS a number of hospitals in Canada have been operating their own transfusion services satisfactorily for a number of years; and

WHEREAS in the opinion of the Canadian Hospital Council there is not adequate surety that the Red Cross will be able to meet the blood transfusion requirements of all hospital patients; and

WHEREAS in agreeing to carry out the actual operation of transfusing the patient as a free service to the patient, the hospitals, out of other revenues, and members of the medical profession are making a very material contribution to transfusion services;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council approve in general the principle of Red Cross participation in civilian transfusion services and urge that contracts in various areas be sufficiently flexible to permit hospitals with well-established blood banks to so operate their blood transfusion services as to safeguard the present and future transfusion requirements of patients, and urge further that there be full and complete consultation between officials of the Red Cross and officials of the Canadian Hospital Council and provincial or regional hospital officials before the Red Cross proceeds to establish transfusion services, make contracts, or proceeds with publicity in any province.

20. Pension Plans

WHEREAS, in the opinion of the Canadian Hospital Council, the adoption of an adequate pension plan for hospital employees is in the best interests of the employees and the hospital;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council urge its member hospitals to make a study of the report of its Committee on Pension Plans and to implement an adequate pension plan as soon as possible.

21. Personnel Welfare

WHEREAS the maintenance of personnel relations, remuneration, working conditions et cetera, equitable to both the staff and the hospital is in the best interests of hospital services;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council urge its member hospitals to provide for the periodic review of salaries, working conditions, housing, et cetera, of its staff members.

22. Public Relations Programs

WHEREAS the maintenance of an adequate public relations program is in the best interests of hospital services;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council urge its member hospitals to establish a local public relations program and to participate in and support provincial and national programs.

23. Routine Chest Admissions

WHEREAS it is imperative that hospital employees be protected to the degree possible against contracting tuberculosis;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council recommend to its member hospitals that the following procedures be endorsed:

(a) The routine filming of all admissions with federal and/or provincial assistance in the financing of this procedure;

(b) A routine Mantoux test for each new employee;

(c) B.C.G. vaccination for all employees with a negative Mantoux; provided the consent of the employee or guardian of the employee (if a minor) is obtained.

(d) Annual chest plates taken on all employees;

(e) More frequent (probably every three months) filming of individuals suspected of having tuberculosis;

(f) Frequent sedimentation rates on individuals suspected of having tuberculosis.

24. Educational Policies

WHEREAS it is considered desirable that hospital personnel have an opportunity of attending institutes, conventions, and/or refresher courses frequently; and

WHEREAS Hospital Associations in the Maritimes, Quebec, Ontario, and the four western provinces of Canada, and the American College of Surgeons, the American College of Hospital Administrators, and the American Hospital Association, all sponsor institutes, refresher courses, and conventions; and

WHEREAS it is considered desirable that the Canadian Hospital Council expand its program for helping in courses designed for the further training of hospital personnel;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council commend all the organizations referred to in this resolution for their progressive policy in sponsoring training courses, and further be it resolved that the Executive of the Canadian Hospital Council consider ways and means for the expansion of the educative work of the Council.

25. Hospital Public Relations

WHEREAS there is need of a more extensive program of hospital public relations; and

WHEREAS it is highly desirable that features of this program be on a national basis;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council cooperate with the provincial and local hospital organizations in the development of this program, the extent of the participation to be dependent upon the ability of the Council to raise sufficient funds to finance the employment of an Assistant Secretary, and the other details involved.

(Concluded on page 104)

◄ Provincial Notes ►

Nova Scotia

NEW WATERFORD. A 105-bed addition to the New Waterford General Hospital has been proposed and the architect has been advised to secure detailed information regarding cost and materials. It is expected that the addition will cost in the neighbourhood of $430,000 without furnishings, and it will be a brick building with steel reinforced, concrete floors, metal stairs, and fireproof stairways.

* * * *

SYDNEY. Representatives of parishes served by St. Rita Hospital met recently to launch a campaign for a new $1,500,000 hospital. The proposed hospital will have a capacity of 150 beds, an increase of 86 over the original structure. It is hoped that $300,000 will be realized from federal-provincial grants, and the Congregation of the Sisters of St. Martha have volunteered to contribute $900,000 toward the cost of construction. About one-fifth of the total cost is yet to be raised by the residents of the district.

New Brunswick

MONCTON. X-ray equipment valued at $35,000 to $40,000 will be installed at the Moncton Hospital. In purchasing this equipment, the hospital is taking advantage of a government grant to improve hospital facilities.

Quebec

CAP-DE-LA-MADELEINE. A new general hospital, costing about $1,000,000 and having accommodation for 155 patients, is to be erected at Cap-de-la-Madeleine in Champlain County and will be operated by the Sisters of Charity. The Quebec government has authorized a $432,000 contribution and it is expected that Ottawa will grant $100,000 toward the cost of construction.

* * * *

MONTREAL. The Jewish General Hospital is drawing up plans for a nurses' training school. Accommodation will be in single rooms, and complete training facilities such as classrooms, science and dietetic laboratories will be provided. An auditorium with a seating capacity for 400 will be used by nurses as well as the medical staff.

* * * *

MONTREAL. The widow of a wealthy surgeon who had practised in the Montreal district for many years until his death a few years ago bequeathed $125,000 to Notre Dame Hospital. The bequest was contained in the will of Mrs. Alma E. Martel, widow of Dr. Stanislaus Martel.

Ontario

CLINTON. Three years of planning and construction reached fruition when the new wing of the Clinton Hospital was officially opened in May. With the new 24-bed wing, which also contains a maternity ward and a 12-cubicle nursery, the hospital now has accommodation for 45 patients. The two-storey structure was erected largely through the contributions of residents of the area.

* * * *

PORT COLBORNE. The first sod was recently turned on the site of the Port Colborne Memorial Hospital marking the beginning of construction of the building. The hospital was made possible by the will of the late Donald McGillivray.

* * * *

HUNTSVILLE. Huntsville Memorial Hospital, a Red Cross outpost hospital, has been opened to serve a district of 12,000 permanent residents and a large summer tourist population. All wards of the 27-bed structure are on the ground floor including the nursery which contains 10 cubicles. The second floor of the $200,000 building, which is frame interlaced with stone, will house the nurses' quarters. Approximately 12 nurses will serve the hospital and there will be an additional maintenance staff of eight persons.

* * * *

SMITH'S FALLS. The Ontario Hospital, under construction at Smith's Falls for the care of children and adults up to the age of 20 years, will be doubled in capacity from that of the original plans and will total 2,400 beds. At present six wings of the residential quarters have been erected and these will be duplicated within the next few years. The main hospital building, the administration building, the nurses' residence, staff houses, laundry, boiler, and bakery buildings, are yet to be erected.

* * * *

TORONTO. At an official ceremony held in April, the cornerstone of the new Hospital for Sick Children was laid. Federal, provincial, and municipal government representatives were among the audience of 250 persons.

* * * *

WIARTON. Through the concerted efforts of residents of the town of Wiarton and the surrounding communities, a 21-bed Red Cross outpost hospital has become a realization. The cost of the $200,500 structure was undertaken jointly by the Red Cross Society, the provincial and federal governments, and by local subscription.

Manitoba

ALONSA. In May the Red Cross Society opened a small nursing station in the village of Alonsa, 143 miles northwest of Winnipeg. The four-roomed cottage, which will also serve as the residence of the nurse, Miss Gertrude M. Doll, is equipped with an operating table and a bed for emergency cases. Miss Doll will look after a community of 1,000 persons, whose nearest hospital is 40 miles distant.

* * * *

CARMAN. Officially opened in May, the Carman Memorial Hospital is the largest rural hospital to be built in Manitoba in recent years.

(Continued on page 100)

Council Meeting

(Continued from page 41)

matter, one medical speaker passed the buck to the clergy.

C.H.C. Finance

A serious discussion took place on the necessity of expanding the work of the Council and of finding the money to finance these activities. Mr. Swanson, as chairman of the Finance Committee, explained the urgent necessity of appointing an assistant secretary, since the Executive Secretary, Dr. Harvey Agnew, is carrying a burden too heavy for any one man. At an earlier session the Executive Committee had estimated the cost of increasing the staff, working space, and facilities required for these activities would be approximately $15,000 at least. Mr. Swanson expressed appreciation of assistance received from the Sun Life Assurance Company of Canada, but reminded the delegates that the contribution made by that Company was being decreased gradually in accordance with its policy of aiding young organizations, whereas the Council was considered to be now full fledged.

Dr. Gilday pointed out that for two decades the burden of the Council's work has rested largely upon Dr. Agnew, whose office provides an advisory service, who frequently visits Ottawa guarding the interests of the field in legislative matters, and who travels widely throughout the year, working on divers hospital matters and coordinating the work of the various associations. Without pulling any punches, he said that if hospitals are to continue to receive this service and get the greater service possible, they must make a larger contribution toward the cost of financing the Council. They must raise at least half of the $15,000 required.

Debate was rapid and animated, various methods of raising the money being considered. It was decided that:

(a) The organization should continue as a Council rather than as an Association;

(b) The Council, after careful thought by its Executive, should expand its activities to meet the most obvious needs;

(c) Efforts should be made to expand the annual income in accordance with these needs;

(d) The incoming Executive Committee consider itself as having received a directive to work out a budget and approach the various associations and conferences and other potential sources of funds along these lines.

National Health Program

Dr. G. D. W. Cameron's luncheon address on "Canada's National Health Program" drew a large attendance. (See this issue, page 31.) The supporting role of the Federal Government was stressed. During the afternoon session much appreciation of the government's construction grant was expressed, but the delegates were emphatic that the basic desire of the government to get on with increased hospital accommodation is being seriously delayed by the Federal policy of not extending construction aid to nurses' residences or essential services (see Resolution No. 12). Nor did the delegates see why the unexpended construction funds should be allowed to accumulate rather than be so used.

The action of the Department in refraining from setting up a committee to make a national study of nursing services was also debated with the Deputy Minister. It was emphasized that the present policy of leaving recommendations to the nine (now ten) provincial study committees and of giving these committees no common basis of approach is bound to result in much confusion both in the studies and in the recommendations. It may lead to provincial action difficult to fit into a national pattern. (See Resolution No. 9.)

Provincial Hospital Plans

Dr. J. M. Hershey, British Columbia Hospital Insurance Commissioner, reviewed details of the plan in that province. He emphasized that the government would not be encroaching upon the medical field since the Act provides for hospitalization insurance only, radiology and pathology having been designated as hospital services. In discussing the Saskatchewan Plan, Dr. Gordon Wride of Ottawa, formerly of Regina, reviewed the experiences encountered under the Saskatchewan Plan. This Plan has proved quite popular, both with the public and with the hospitals. It is not possible yet, however, to estimate the cost of hospitalization inasmuch as costs are still rising.

Mr. G. W. Myers of Regina, in a point by point analysis, showed how closely the Saskatchewan Plan was following the principles layed down some years ago by the Canadian Hospital Council in a brief presented at Ottawa, outlining what the Council would desire a compulsory plan to cover if and when such a plan should ever develop. These opening addresses, and that of Mr. John Smith of Yorkton, elicited much discussion on this subject.

Hospital Accounting

In presenting the report of the Committee on Accounting, Mr. Percy Ward, retiring chairman, recommended that the Canadian Hospital Council re-define the duties of its Committee on Accounting and form a new committee with instructions to collaborate with the Dominion-Provincial Conference on Statistics and Accounting at future meetings. This committee, he said, should concentrate upon protecting the interests of hospitals, particularly the smaller ones. Mr. Swanson expressed, on behalf of the C.H.C. Executive, deep appreciation of Mr. Ward's untiring services as chairman of the Accounting Committee for the past ten years.

Mr. George N. Barker, successor to Mr. J. C. Brady as Chief, Institutions Section, Health and Welfare Division, Dominion Bureau of Statistics, presented a paper in which he outlined to date progress made by the Dominion-Provincial Conference.

Hospital Finance

Various phases of finance—costs, possible economies, and rates — were introduced by Mr. Murray Ross of Edmonton, Sister Kenny of Chatham, and Judge M. George, Morden, Manitoba. The latter sounded a warning against the possibility of over-building. In his opinion hospital authorities should concentrate on district hospitals

(Concluded on page 94)

Des Visites

(suite de page 43)

heure convenable, ne restent pas longtemps, ne s'asseoient pas sur le lit, se placent du côté qui accommode le malade et causent de choses vraiment intéressantes.

(Ce détail de se placer de manière à ne pas fatiguer le visité, est plus important qu'on le croit ordinairement. On prévoit même, dans de nouvelles constructions, l'agencement des prises de courant d'un seul côté de la chambre. Le lit longera le mur, on y laissera tout juste l'espace pour circuler, et les meubles et les sièges seront placés du côté libre.)

Le personnel des hôpitaux devrait encourager ces visiteurs à revenir, car ils font du bien au malade et peuvent contribuer à son rétablissement.

Que ne pouvons-nous obtenir des parents de cacher leur douloureuse émotion sous un visage serein et confiant! Une profonde affection saura se taire en certaines circonstances. L'expression des traits, une attitude remplace bien des paroles.

Il faut que la visite soit suffisante et bien choisie. Soupçonnons-nous la souffrance morale du malade en salle commune, se voyant délaissé parce qu'il n'a pas de parents, à côté d'autres entourés d'une couronne de visiteurs? La solitude d'une chambre privée n'est pas plus attirante. Le cher malade abandonné ne peut que ruminer de sombres pensées. Qu'on vienne par politesse, par curiosité, par sympathie, il faut qu'avant tout la visite soit salutaire. Pour être bienfaisante, la visite ne doit pas fatiguer le malade. Les visites courtes sont les meilleures. Elles doivent être empreintes de calme et de discrétion. Chacun doit savoir écouter le malade en montrant des signes d'intérêt. De parler, de tout dire le soulage. "Après avoir écouté, nous aurons acquis le droit de nous faire entendre, mais pas avant" (R.Père Richer -M., O.F.M.). Il sera donc facile ensuite de placer quelques bonnes paroles, de lui inspirer foi en sa guérison; d'évoquer les jours meilleurs et prochains où il retrouvera dans ses occupations, la joie et la douceur de vivre; de lui prêcher la patience pour admettre et supporter la durée de son état; de suggérer l'abandon à une volonté supérieure à la sienne, dont les vues dépassent parfois notre pauvre entendement, mais en qui l'on trouve le soutien et la grâce pour les heures difficiles.

Le tact est plus précieux que l'or dans ces occasions. L'adaptation s'impose. Le malade se fatigue vite. Que son visiteur soit joyeux, naturel, voire spirituel. Que la conversation roule sur des sujets qui intéressent et non sur des choses tristes. Qu'on alimente et dirige la conversation. Il faut être prodigue de sympathie, mais parcimonieux de pitié. La première soutient, l'autre humilie. Au visiteur de cacher son inquiétude ou son anxiété, car le malade épie son expression. Que cette expression soit rassurante. La maladie, les douleurs, qu'il aide à les oublier. Les souffrants ont besoin d'encouragement. Attention donc; le regard s'accoutume vite aux misères d'autrui, car ce qui ne nous broie pas personnellement cesse vite de nous émouvoir. Souvenons-nous que l'espérance, la confiance, la foi ont des effets curatifs étonnants quand ces vertus sont soutenues par la prière. En effet la foi et la prière sont les deux plus grandes forces morales qui peuvent aider dans la lutte contre la maladie et la souffrance. L'équilibre magnifique que donne la foi chrétienne n'est-il pas le meilleur élément de l'équilibre physiologique?

La visite aux enfants

1) L'enfant peut-il visiter l'hôpital?

Dans un questionnaire adressé à trente petits hôpitaux américains, neuf ont répondu qu'ils ne possédaient pas de règlements spéciaux aux sujets juvéniles, et les autres défendaient l'entrée de l'hôpital aux enfants en bas d'un certain âge qui varie de 12 à 16 ans, la moyenne

Nurses, Welfare Workers, Teachers, Required for Northern Canada

An attractive opportunity to share in the development of Canada's Arctic and sub-Arctic areas is presented in the call for qualified social welfare workers, nurses, and teachers, being issued jointly by the Hon. Colin Gibson, Minister of Mines and Resources, and the Hon. Paul Martin, Minister of National Health and Welfare. The Northwest Territories Administration and the Department of National Health and Welfare are working together to develop a new program of health and educational services in the Territories.

The increase in the number of persons now living in the far north has resulted in the establishment of new nursing stations and schools, and an effort is being made to establish co-ordinated community services to make life in the Territories healthier and more agreeable.

Nursing stations are designed to serve as dispensaries for those requiring medicines and treatment for minor ailments and to provide nursing care for persons in need of short periods of hospitalization. They are also a means of ensuring proper and immediate attention for medical cases until the services of a doctor are available. The nurse in charge of such a station is in frequent contact by radio with the nearest medical officer.

Welfare teachers are expected to carry on welfare work and to give leadership in all local activities designed to improve community life. They will organize recreational programs and measures for adult education, visit the homes, do investigation work, and endeavour in all ways to improve the general welfare of the communities.

Working together, the nurse and the welfare teacher will take every precaution to maintain community health. They will encourage attention to such matters as proper preparation of foods, improved housekeeping methods, and personal cleanliness. They will work to prevent the spread of disease and to maintain a good community spirit.

The Northwest Territories Administration is particularly interested in hearing from married couples wishing to work in the north. The most desirable combination is that in which the wife is a trained nurse or social welfare worker, and the husband a qualified teacher.

Enquiries concerning opportunities for service in the north will be welcomed. They should be addressed to: R. A. Gibson, Deputy Commissioner, Northwest Territories Administration, Ottawa; or, Dr. P. E. Moore, Director, Indian Health Services, Department of National Health and Welfare, Ottawa.

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étant de 13.2. Dans deux ou trois cas, les enfants sont admis, sauf à la maternité, et dans un hôpital on ne tolère que les enfants du client.

Dans les hôpitaux où les règlements défendent l'accès des enfants aux chambres, des hôtesses ou des jeunes filles bénévoles en prennent soin et les amusent.

Dans nos hôpitaux canadiens, on tend de plus en plus à interdire l'entrée des enfants visiteurs. C'est prudence et sagesse. Reste à souhaiter que tous les hôpitaux de la province s'unissent dans un même effort pour établir ce point disciplinaire qui favorise l'intérêt du malade en supprimant une cause de bruit, et celui de l'enfant visiteur en l'éloignant d'un milieu où il peut facilement se contaminer.

2) L'enfant peut-il être visité?

Quelques administrateurs ont répondu en ce sens; les enfants en chambre privée peuvent recevoir.

Les enfants peuvent être visités tous les jours, mais nous dissuadons les parents de venir si l'enfant est très jeune. Nous permettons à la mère de rester la première nuit, si elle y tient absolument. D'ordinaire, la mère se rend compte que l'on prend bien soin de son enfant et s'en tient subséquemment aux heures de visite.

Si l'enfant s'émeut trop au départ des parents, nous demandons à ceux-ci de se borner à voir le petit malade à la dérobée.

Seuls les parents (père, mère) sont admis à l'aile des enfants et nous éconduisons avec tact la grand'mère, les tantes et même les voisines qui s'amènent avec les raisons les plus étonnantes pour tenter d'être admises "même si ce n'était que pour un instant".

Nous essayons de dissuader les parents de rester auprès de leur enfant hospitalisé, sauf si son cas est désespéré.

La suppression de la visite auprès des enfants semble se généraliser; du moins, paraît-on vouloir en limiter les heures. L'essentiel est de préserver l'enfant de toute contagion apportée du dehors. Le mur à claire-voie ou vitré, où l'enfant peut être vu sans passer dans les bras des parents, est la seule garantie.

La visite en obstétrique

Quelle est la meilleure ligne de conduite à suivre pour empêcher les visiteurs ainsi que les enfants de moins de 14 ans d'avoir accès à la maternité? Voici les quelques réponses reçues à notre enquête:

C'est une difficulté que l'on a retranchée avec succès dans certains hôpitaux en remettant des laisser-passer aux visiteurs. On donne, au mari, une carte sur laquelle sont inscrits son nom ainsi que le numéro de la chambre de son épouse. Cette carte l'autorise à se rendre vister sa femme. En plus de son époux, chaque cliente peut recevoir deux visiteurs adultes par jour.

Avant la naissance, le mari peut demeurer avec sa femme à toute heure. On n'accepte que le mari au cours des trois premiers jours. La mère ne reçoit pas quand son nouveau-né est auprès d'elle.

On tente d'expliquer aux visiteurs que les enfants ne sont pas admis à l'étage de la maternité afin de favoriser le rétablissment et le repos des malades.

Ceci dit, on admettra que c'est bien l'endroit où les restrictions semblent plus difficiles à imposer et où le succès est le plus précaire.

La visite aux salles d'opérations

Nous avons reçu des réponses particulièrement intéressantes à la question suivante: Vous arrive-t-il de laisser entrer des visiteurs (excepté des médecins) à la salle d'opération. et si oui, dans quelles circonstances?

Vingt-et-un hôpitaux ont répondu tout simplement. "Non". Les dix autres ont répondu qu'ils ne le permettaient, avec le consentement du chirurgien que dans certaines occasions bien exceptionnelles. Mais, apparemment, les hôpitaux qui admettent des visiteurs aux salles d'opérations, éprouvent le besoin de s'en justifier.

Un administrateur exprime en ces termes l'opinion de la majorité: "Non, nous ne faisons jamais d'exceptions dans ce cas-là. Nous considérons que c'est là une pratique dangereuse, que rien n'autorise, et qui va à l'encontre de l'intérêt bien compris du malade, car ni l'anesthésiste ni le chirurgien ne peuvent discuter à l'aise du cas d'un patient en présence de personnes étrangères à la profession".

Le docteur MacEachern, interrogé lui-même, dans un forum, lors du Congrès des Hôpitaux catholiques, tenu à Québec en août 1948, répondit: "Non"; mais il a ajouté: "S'il y a des parents qui assistent à la dernière phase de l'intervention, ils doivent garder un silence rigoureux et être revêtus de la blouse blanche et du couvre-bouche".

La visite aux malades mourants

Voici au moins une circonstance où nous pouvons user de libéralité envers les visiteurs. Jamais nous ne témoignerons trop de sympathie à la famille d'une grand malade dont la mort approche. Non seulement il faut encourager, mais il faut respecter la présence des membres de la famille au chevet d'un mourant et nous devons avoir pour eux toutes sortes d'égards. Il faut alors ignorer les heures des visites; mettre un parloir à la disposition des parents afin qu'ils puissent s'y retirer pour ne pas fatiguer le mourant et ne pas s'épuiser eux-mêmes. Servir une collation au cours de la nuit est toujours bien apprécié.

La visite venue de loin

Passons maintenant aux visiteurs *éloignés*. C'est sage de prévoir des exceptions aux heures de visite réglementaire; si un visiteur n'est pas de la ville, il mérite une attention particulière.

Les visiteurs venant de loin devraient pouvoir faire une visite de dix à quinze minutes, si le moment de leur arrivée est trop distant des heures régulières d'accès.

Pour justifier les exceptions à la règle établie, considérons que nombre de visiteurs viennent de très loin et qu'ils sont exposés aux vicissitudes des horaires d'autobus ou de chemin de fer, aux pannes ou aux exigences de leur devoir d'était. Il serait par trop dur de les rebuter en pareilles circonstances pour le plaisir de s'en tenir au règlement.

Il est vrai que certaines gens abusent parfois. Ils ont tous les prétextes pour quelque visite en dehors des heures fixées. Leur travail ne leur permet pas de faire autrement, ils ne savaient pas, et cetera.

Mais il y a sûrement des exceptions justifiées, comme lorsque le mari travaille le jour et ne peut visiter sa femme que le soir.

(à suivre en juillet)

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Fire Prevention

(Continued from page 37)

tend at least 2 feet above any ridge within 10 feet and should be at least 3 feet above any part of the roof they contact. And finally, the chimney should be properly capped with a non-combustible weather-proof material. The roof fire hazard may be reduced by use of asphalt shingles, metal roofing or other fire resistant coverings.

Fire retardant paint has a definite place in protecting many of our smaller frame hospitals. I have strongly advocated its use, particularly in such areas as roof spaces that are not readily accessible.

Combatting a Fire

Panic is a terrible thing, and this can be avoided by a well-trained hospital staff. The fire alarm itself may start such a panic if it is too noisy and unless the staff and patients are familiar with it. Therefore, one solution is to have the tone of the alarm such that it will call the attention of staff without unduly alarming the patients with its raucous clanging.

Constant fire drills are the best answer, but one finds both doctors and hospital staff often opposed to this practice, usually on the grounds that it disrupts the smooth running of the hospital and upsets the patients, as well as causing considerable additional work.

I have seen a satisfactory system in operation in St. Luke's Hospital in New York City. Here, fire alarm boxes are located on each ward and each box has a different code. When an alarm box is pulled, the system rings the code of that box throughout the hospital. The personnel were well trained and all seemed familiar with the rather complicated code of signals. Copies of the code were placed in all elevators, corridors, and on notice boards. Practice fire drills were held every two weeks and when they occurred, all wards were required to shut doors and windows and prepare for evacuation of patients. The special six-man fire fighting squad was often able to be on the ward within 30 seconds after the call had been placed.

It is important that all hospital personnel know which end of an extinguisher to pick up and how to fight fire. Practice drills should be held with groups of staff, at which time they should pick up extinguishers and extinguish actual fires.

In areas where grease fires are likely to occur, such as in kitchens and ward pantries, carbon dioxide foam type or vapourizing liquid extinguishers and an asbestos blanket should be readily available. There should be a rigid system of inspection of all fire fighting equipment.

The suggestion of a garden hose located in the basement of a hospital, with water pressure continuously on the hose and controlled by a shut-off nozzle, appeals

Dominion Regulations for Fire Prevention in Hospitals

(The bulletin from which these standards are reprinted was prepared by the Department of National Health and Welfare for use in its approval of construction projects under the National Health Program, 1948-1949.)

(a) Every hospital of over one storey in height shall be of fire resistant construction, in conformity with the National Building Code. The basement shall not be considered a storey for the purposes of this section. No patient shall be accommodated or treated above the first storey in any hospital building, if the building is constructed wholly or mainly of wood.

(b) Suitable fire exits and fire escapes, approved by the Provincial Fire Marshal, shall be provided for every hospital. There shall be, at least, two independent means of egress from every floor and from every separate section of a floor. These stairs shall be located as remotely as possible from each other. Inside stairways that form part of a fire escape system shall be of not less than three hours fire resistant construction.

All exit facilities and fire escapes shall be of a type suitable for the removal of patients in case of fire and shall be so lighted that they can be used with safety at night. Illumination for such exit facilities shall be on a separate circuit.

(c) In every hospital there shall be a system of fire control and provision for fire extinguishment. It shall include an electrically or manually operated fire alarm system. Such an alarm system should be modulated so that it comes promptly to the attention of the staff but not necessarily to the patients.

(d) When possible, there shall be sufficient stand-pipes and hose to permit effective fire fighting in any part of the hospital. There shall also be sufficient chemical or other hand-operated fire extinguishers and they shall bear the approval label under the Underwriters' Laboratories Incorporated to afford ample protection against an incipient fire in any part of the hospital. As well as the above, every laundry chute, dumbwaiter, or elevator shaft, in a hospital of over two floors, shall be lined with fire resistant material and shall have sprinkler heads at the top of each shaft, supplied from the domestic water system. Sprinkler heads shall fuse at not less than 165 degrees F.

(e) All hospitals should have basements of fireproof construction with reinforced concrete floor above. Bearing walls in basement are to be masonry or concrete; other partitions, wood and metal lath or gypsum lath construction. If local conditions prohibit this type of construction, then boiler rooms attached to or forming part of a hospital shall be cut off from the building by means of self-closing fire doors. Walls, floors, and ceilings shall be of fire resistant material. Each furnace and boiler room shall be provided with a direct exit to the outside.

A masonry or concrete vault with floor and ceiling ventilation shall be provided, whenever possible, for the storage of all flammable anaesthetic agents, flammable or explosive drugs, chemicals and alcohol.

to me, because it is instantly available and easy to handle. When not in use the hose can be laid over pegs on the wall in convenient location.

Evacuation of Patients

On this point let me quote from a letter of a superintendent of one of our larger hospitals. He says, "Should a fire occur, I have often wondered how well we could evacuate bed-ridden patients down a standard stair. To my mind it would be almost impossible to accomplish".

Let me also quote from our *General Standards* in this regard: "There shall be, at least, two independent means of egress from every floor and from every separate section of a floor. Stairs shall be located as remotely as possible from each other. Inside stairways that form part of a fire escape system shall be of not less than three hours fire resistant construction."

The type of stair which is closed off from the rest of the building is eminently more satisfactory than the ordinary exterior fire escape but, unfortunately, many of our smaller hospitals are converted houses, where the stairs are neither enclosed nor fire resistant.

There has been considerable study put into how wide an exterior hospital fire escape should be. Some say they should be wide enough to allow fire fighters to ascend while patients are being carried down. This would require about 44 inches. Others suggest that a rescuer carrying a patient down on his shoulders would want to grasp the fire escape handrail on either side and the 36 inches would be wide enough, but not too wide. These wider widths of escapes cannot be safely supported from brackets on the hospital wall, but would need support from the ground. Wired glass should be used in all windows that are adjacent to fire escapes. Otherwise, the escape may become impassable.

There are many of our smaller hospitals that have fire escapes constructed of wood. Normally, the depreciation of the wood renders it impracticable; also snow and ice form more readily on the wider surfaces and they must be kept clear. However, if the building itself is of wood, the wooden fire escape should last as long as the building. It would require painting to keep it in shape. Fire retardant paint would serve a dual purpose.

Although architects generally deplore having their buildings marred by fire escapes and particularly by the chute type, for our smaller hospitals that have two or three floors, one cannot help but favour the chute method of conveying the patient rapidly to safety. The chutes can usually be placed in the rear of the building where they are not unduly conspicuous.

Each floor should have individual chutes sloping from exit doors to the ground. The patient lying on a mattress is deposited on the chute and slides to the ground. By this method one has a speedy way of removing bed-ridden patients from the building.

In conjunction with this type of escape, the carrying of the mattress with a patient on it presents a problem. Different solutions have been adopted by various hospitals, such as handles on the mattress, or loops through which poles are inserted to form a stretcher, or two straps under the mattress which are fastened around the patient and mattress and these straps then used to carry the patient to the chute. All these systems have been found satisfactory but require constant checking to ensure that handles, loops, et cetera, are in good repair.

One should mention here the problem of using elevators for the removal of patients in case of fire. If it is a large hospital with banks of elevators located in different parts of the building, those elevators that are remote from the fire might be used. In smaller hospitals with one or two elevators close together, there is the danger that the fire may spread to parts of the elevator equipment and cause it to jamb between floors, or the opening of doors may increase draught and fill the shaft with smoke.

Combustible Anaesthetics

About every year or so, one hears of a fatal accident occurring in hospitals due to the explosion of combustible anaesthetics in operating rooms. Obviously, there is risk in using mixtures that may be violently explosive, but the use of closed rebreathing systems for the administration of anaesthetics tends to restrict the hazardous area, and a proper ventilation system in the room where the anaesthetic is administered will reduce the extent and duration of such a hazard.

The danger occurs when the room has an explosive mixture in it and a spark or sufficient heat is present to ignite it. For example, a flash from electrical equipment, use of cautery instruments in a hazardous location, or static electricity, may cause an explosion.

Static electricity can be greatly reduced by introducing humidity into the O.R. via the ventilating system, but it is not sufficiently reliable for the complete elimination of static. Many doctors, however, object to working in a room with high relative humidity and high temperature. Some hospitals that do not have controlled humidity partially achieve this objective by means of escaping steam from adjacent autoclaves. Conductive flooring and grounding of equipment are recommended and should be included.

Anaesthetic gases are nearly all heavier than air and, therefore, the floor is a hazardous area. All electrical outlets should be about 4 feet above the floor level and of an explosion proof type. One architect I know places light switches to O.R.'s outside the room. All exposed metal parts of equipment should be grounded, and motors used in O.R.'s must be of the explosion proof type.

Even with all these precautions, the most effective safeguard is a continuous consciousness on the part of the operating room personnel of the danger inherent in the use of flammable anaesthetics. This applies not only in the operating room but in other parts of the hospital, wherever explosive agents are stored.

Ether is so commonly used in a hospital that one is inclined to ignore its potential danger. I heard of one old gentleman, a country practitioner, who administered

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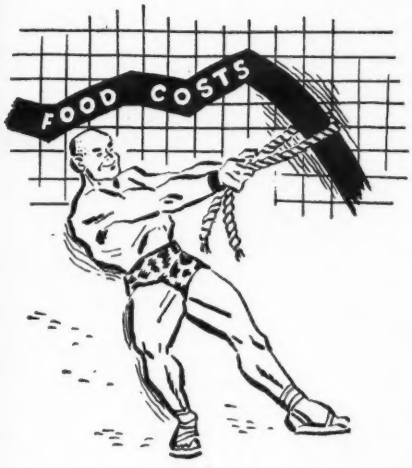

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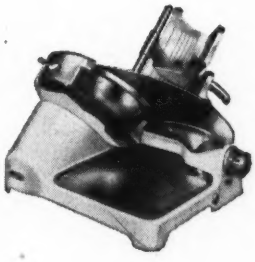

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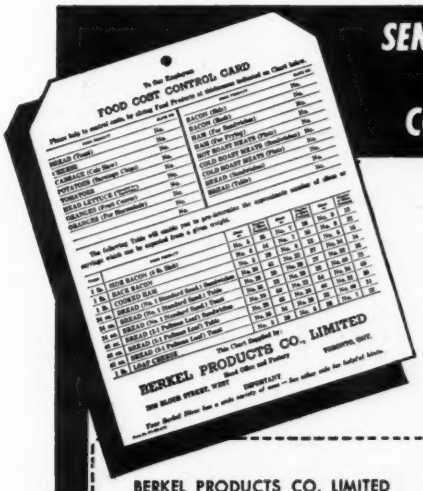
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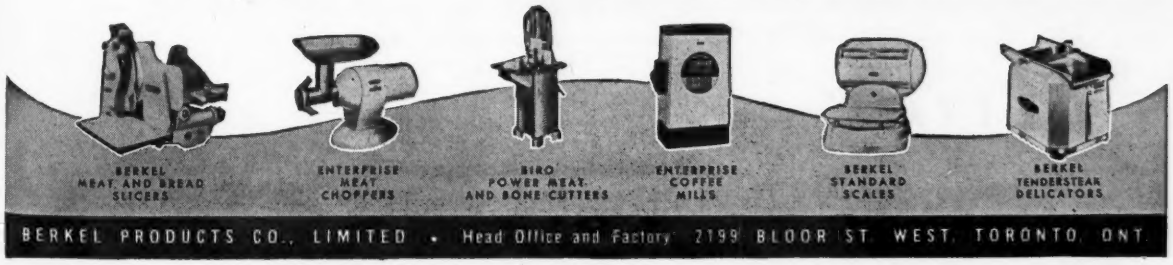

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ether to a patient while smoking a cigar. Nothing happened in this case, but then take the example of a nurse who wore silk or sharkskin into an operating room. The friction of her fountain pen on the material caused a static spark and an explosion.

Conclusion

I would like to make a few suggestions for those who are concerned with fire protection in our hospitals.

First, architects must be fire protection conscious when planning a hospital. It is their duty to eliminate the fire hazard whenever possible and to inform their clients, the hospital board, of the potential danger of fire. They should recommend fire resistant materials and explain the fallacy of being "penny wise and pound foolish" when people's lives may be at stake. Besides conforming to the fire regulations of their district, they should seek out the advice of fire prevention authorities in their area.

Secondly, a word to hospital superintendents and hospital boards. You are responsible for the well being and safety of your patients. You cannot afford to gamble with their lives. Your hospital should have the most suitable equipment for detecting and combatting a fire. There should be sufficient and adequate exit facilities so that occupants can be rapidly and safely evacuated if the need arises. Your hospital staff should be organized into a fire wardens' service and well drilled under the supervision of the local fire chief so that each individual knows what is expected of him in cases of emergency.

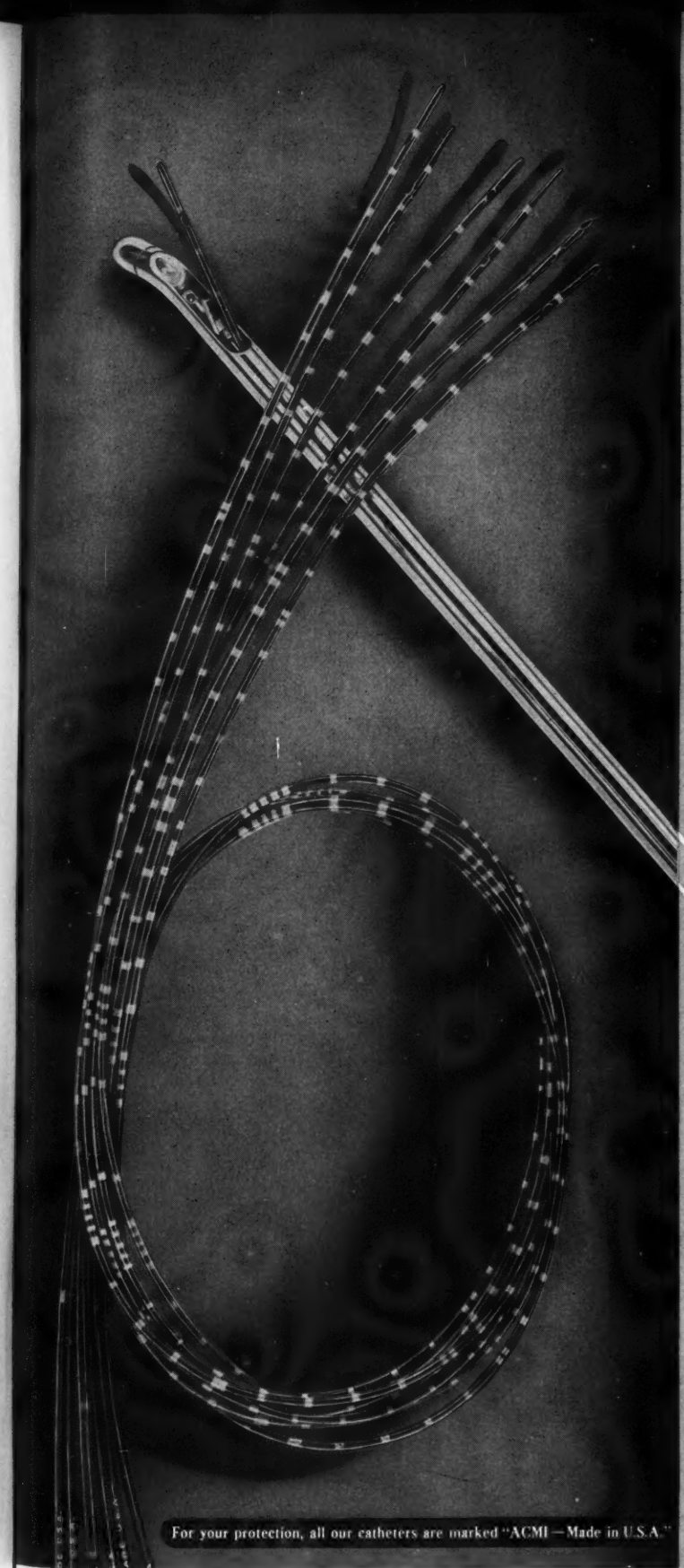
Last, but not least, a word to the fire prevention authorities themselves. Know the hospitals in your district. Be familiar with the plan of the building and know the danger spots. For example, if a hospital has a piped oxygen system, know where the tanks are and how they can be disconnected.

Develop an education program; send firemen to instruct hospital staffs in the use of equipment. Study hospital fires that have occurred, learn from them, and explain the dangers by giving examples of actual tragedies. Produce a practical plan, in conjunction with the hospital authorities, for the removal of patients, and remember when doing so that the great majority of the hospital staff are women.

Finally, be diplomatic, gain the confidence of hospital authorities and obtain their co-operation; more can be accomplished by this method than by being too arbitrary.

Plans Proceeding for Western Canada Institute

Plans are well under way for the Western Canada Institute for Administrators which is to be held in Regina, October 3-8. The faculty will consist of well-known leaders in the hospital field, and at least two representatives from each of the other three western provinces will take an active part. The Saskatchewan Hospital Planning Commission will also participate. Details of the program will be published in a future issue.



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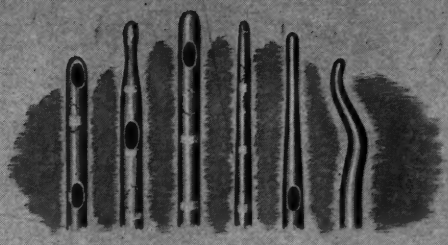

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Health Program

(Concluded from page 62)

ent program includes a special cancer grant of $3,590,093 to be matched dollar for dollar by the provinces. This is to enable them to mobilize special facilities for the diagnosis and treatment of this disease.

Already many projects have been received from across Canada. Great schemes are in the making. The recently formed National Cancer Institute, ably supported by the Cancer Society, is playing its part by assisting with technical advice. It is also setting up a national tumour registry in Ottawa in technical consultation with our Laboratory of Hygiene. Only time will tell how much suffering can be prevented by these measures. Certainly renewed vigour is being put into the fight.

The last of the grants is that designed to assist in the establishment of an intensive program for prevention, correction, rehabilitation and training services for crippled children. The total amount is $515,944.

Conclusion

In concluding these remarks it is possible to give you a few facts which may serve as an index of progress to the end of the first fiscal year, that is to say, to March 31st this year. In looking at this picture it must be borne in mind that the grants were first announced on May 14th, 1948, that provincial officers were first given a detailed outline of the scheme on June 7th, and that the first project reached Ottawa on August 25th last year. Thus the actual operation period under discussion covers about seven months.

In this time, and from what might be called a standing start, well over fifteen million dollars, out of the thirty million available, has been allocated to approved projects and approximately half of this money has been actually expended on equipment or work done.

It is quite unnecessary to emphasize to you the complexities, difficulties, and delays, inevitably associated with a tremendous undertaking such as this. You know only too well what is involved in erecting a hospital; the same or similar problems confront those who plan in other areas of health work. Probably the greatest single factor holding back new projects is the lack of trained personnel. It is for this reason that so much of the grant money is going into training at the outset of this scheme.

Every health department in the country has had to tackle this great planning job in addition to their normal duties. They have enjoyed splendid aid and encouragement from organizations such as the Canadian Hospital Council, the Canadian Medical Association through its provincial divisions, and the universities and voluntary agencies. Too much cannot be said in praise of the men and women who have faced up to this challenge and have accomplished so much in such a short time.

Erratum

In publishing the listing of schools for laboratory technologists approved by the Canadian Medical Association in the March issue of this journal, the name of the Vancouver General Hospital was omitted in error. The director of the laboratory is Dr. H. K. Fidler and the course of training provided is listed as "General Certificate".

◄ Blue Cross ►

Hospital Charges Made To Blue Cross Subscribers

Dr. F. W. Routley, secretary of the Ontario Hospital Association, has written this to member hospitals:

"It has been stated that some of the hospitals in Ontario which are charging higher rates for non-resident patients than patients in their own communities, are only charging these higher rates to Blue Cross patients and not to others.

"We have no knowledge at the moment as to the truth of this statement. However, we would like to point out that the hospitals of Ontario should not treat Blue Cross patients in any different manner than they treat the individual patient who pays his own way. If you do that, you are simply making it that much harder for people who are attempting to build up reserves for themselves in a prepayment plan such as this, to meet their hospitalization, to do so. Every rate which is paid by Blue Cross patients which is a higher rate than would be paid if the patient were not a Blue Cross patient, is adding to the sum total of the costs which have to be levied against these patients in the whole prepayment plan.

"This plan, as I am sure all hospitals understand, was established and is operated by the Ontario Hospital Association and in that sense is, to some extent, the responsibility of every member hospital of the Association in the Province. It is, therefore, as necessary for every hospital to do everything possible to make the Plan a success as for those in the central office who are committed to its operation."

* * * *

Success of Voluntary Plans

The method for prepayment of hospital bills through Blue Cross Plans was conceived in the public interest and has developed into one of the greatest voluntary trusts in the history of organized society. These Plans stand today as convincing evidence of the ability and determination of individuals to evolve a pattern of protection to serve their needs through voluntary effort.

—*"The Blue Cross Concept" Council on Prepayment Plans and Hospital Reimbursement, A.H.A.*

Trustee and His Job

(Concluded from page 39)

Take your trustees through the hospital and show them what is being done. A new trustee should become thoroughly acquainted with the hospital before he begins his duties. Arrange trips through the hospital to see improvements made, the rearrangement of facilities, the handicaps because of lay-out. Every serious minded trustee would like to know the personnel needs of his hospital. Get him acquainted with as many of the staff as possible.

From time to time call on certain trustees for counsel and guidance. One may be an expert in the field of investment; another trustee may be experienced in personnel relations. The administrator who is most successful is one who gets his trustees to work. Keep them busy. If they feel that they are contributing something, they will work harder. Encourage them to attend all meetings of the board and to serve faithfully upon any committee to which they are appointed. Should a trustee find himself a patient of the hospital, the administrator should see that the hospitalized board member is given every opportunity to see the wheels go round. Encourage the trustees to attend annual hospital conventions and regional meetings.

Some hospitals arrange a "trustee seminar". Here, the general organization is explained by means of a chart.* Then the chief of the medical staff describes the organization of the staff and the medical service. Luncheon, dinner or supper may then be served. After this recess, the dietitian, the director of nursing, the housekeeper, or the accountant, outline their respective activities in a ten-minute paper. The trustee should learn as much as possible about the functions and operating of other hospitals in the community. I believe that the time is now ripe for an "institute for trustees" in this province, lasting from one to two days, and planned on the same basis as the institute held in London last year.

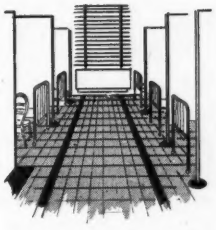
In this province approximately 1,500 citizens from all walks of life are serving today as hospital trustees. They are giving generously of their time, their ideas, and their talents, with all too little recognition. Better understanding between the hospital trustee and the administrator would enhance their value to the institution. All of us who work in and with hospitals have much to learn from each other. The need for the education of the trustee, especially of the new trustee, is obvious, but they with their more objective viewpoint can educate us too.

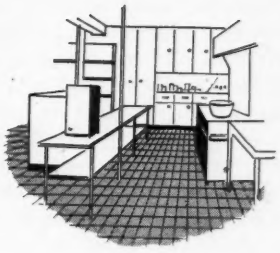
**The most effective way is to have stencilled or photostated copies for each member. For purposes of discussion, sections of the over-all chart may be placed on the blackboard or on lantern slides.*

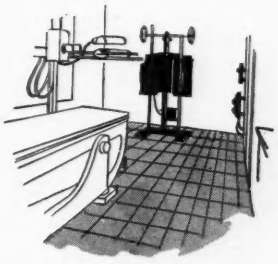
Old Age Pensions for the Yukon

According to an agreement, announced last month, between the Commissioner for the Yukon Territory and the federal government, residents of the Yukon will benefit through the payment of federal old age and blind pensions, effective as of April 9. About 120 persons are estimated to be eligible for the old age pension.

There's an ARMSTRONG floor for every hospital need







There is no **one** floor which is ideally suited for every hospital need. Hospitals present a variety of flooring problems calling for materials with special characteristics.

It is true, of course, that all floors for hospital use must be durable and easy to clean. Richness of colour and design are also usually desired, and can be obtained today at no extra cost. But under certain conditions other characteristics are particularly important. In some floor areas, for instance, quietness and comfort underfoot are the most essential requirements; in others resistance to grease and chemicals; and in still others a high degree of conductivity.

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Useful Manual on Colour Compiled by C.I.L.

A manual on colour conditioning for hospitals has recently been issued by Canadian Industries Limited. It is designed primarily as a guide for hospitals in choosing colour schemes both for decorative and utilitarian purposes. The detail of the painting work, such as scope, procedure, and suitable materials, is stated concisely and adequately, and the number of different colours is restricted so that large stocks of paint will not be required.

The manual contains a guide showing actual colours of paint and the combinations which may be used effectively. These are indexed under headings such as: reception and administration; clinical services, including solaria, corridors, doctors' lounge, waiting room, private and semi-private rooms, wards, operating rooms, laboratories, et cetera. Another section is devoted to service departments and the final section to safety code colours which have been approved for use by safety engineers. It is suggested that a colour code be adopted for piping in plants so that they can be recognized easily as safe, dangerous, protective, firefighting, or extra valuable.

This manual should be of interest to those who are planning either new decoration or re-painting of existing buildings. It is available on loan from the Library of The Canadian Hospital Council, 280 Bloor Street West, Toronto, or further information may be obtained from Canadian Industries Limited, Laughton Ave., Toronto 9, Ontario.

Coming Conventions

June 12—Maritime Conference, C.H.A., Halifax, N.S.

June 13-15—Maritime Hospital Association, Nova Scotian Hotel, Halifax.

June 13-15—Maritime Hospital Auxiliary Association, Nova Scotian Hotel, Halifax.

June 13-17—Canadian Medical Association, Saskatoon.

June 15-17—Canadian Dietetic Association, Fort Garry Hotel, Winnipeg.

June 16-18—Maritime Institute for Administrators and Trustees, Halifax.

June 27-29—Catholic Hospitals of the Province of Quebec, Montreal.

June 27-July 1—A.H.A. Institute on Hospital Pharmacy, University of California, Berkeley, Cal.

July 3-5—Canadian Society of Radiological Technicians, Halifax.

Sept. 24-25—American College of Hospital Administrators, Cleveland.

Sept. 26-29—American Hospital Association, Cleveland.

Oct. 3-8—Western Canada Institute for Administrators, Regina.

Oct. 31-Nov. 2—Ontario Hospital Association, Royal York Hotel, Toronto.

Nov. 2-4—Associated Hospitals of Alberta, Palliser Hotel, Calgary (changed from 7-9).

Nov. 17-18—B.C. Hospitals Association Convention, Vancouver Hotel, Vancouver.

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Small and Large Hospitals

(Continued from page 56)

bookkeepers; and in human relations and personnel management. In more specialized or limited fields — dietetics, public relations, engineering, laundry management, et cetera—fellowships have been awarded for the regional institutes conducted by the American Hospital Association.

Trustee Education. In recent months a series of "institutes" has been developed for hospital trustees. They are four-hour sessions of the discussion type, held usually from 4 to 6 p.m. and again from 7 to 9 p.m., following dinner. Held in various parts of the Region for groups of four or five hospitals, attendance has been good—over 50 per cent. These trustee institutes have served to get across concepts and ideas where large formal meetings and individual board meetings have failed.

Hospital Facilities. The Regional Council staff has made a thorough survey and written report on the building and equipment needs of each hospital and area in the Region, and acts as hospital consultant on a $6,000,000 building program for 14 hospitals outside of the largest cities. The Council will make grants totalling $1,000,000 toward these projects,* in addition to an estimated $1,500,000 of federal funds.

Advice is also given regarding equipment to be purchased by member hospitals. For example, by re-drawing specifications for an x-ray equipment purchase, we enabled a hospital to meet its needs with an outlay of $7,000 instead of the $13,000 recommended by the x-ray supply firms.

Co-operative Efforts

Two co-operative efforts stand out in the Regional Council's activities. The *Rochester Regional Blood Program* of the American Red Cross was pioneered by the Council and is directed jointly by the Council and the Red Cross, with supervision of professional aspects by the County Medical Societies. Last year the Regional Blood Bank collected and distributed more than 25,000 pints of blood without cost to patients, and met the entire blood needs of every hospital in the Region.

Twenty-four member hospitals participate in a *central purchasing program* which has done a business of nearly $250,000 in its first year, with estimated saving of between $30,000 and $50,000.

Standards for many phases of hospital organization and operation have been developed over a period of three years. This has progressed somewhat slowly because—and this is important to remember — the standards have been initiated by the Council members themselves, through the Administrators' Conference, Medical Conference, and Board of Directors, and represent their thinking and their desires.

(Concluded on page 92)

**The Commonwealth Fund set up this amount of money to be used by the Council in aiding hospitals to meet their construction needs and in providing for the rational distribution of hospital beds.*

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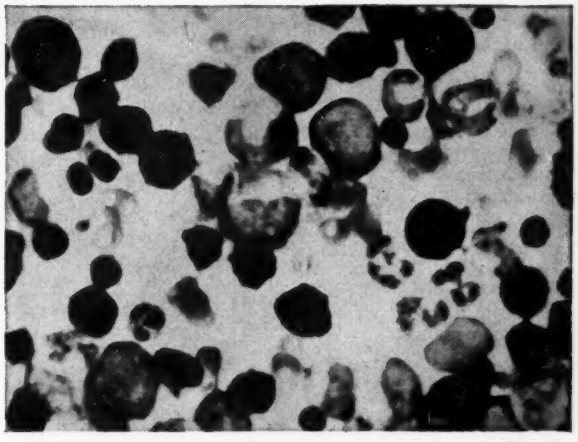
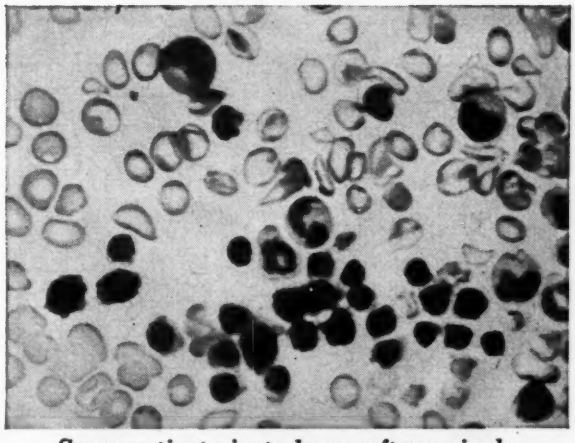
- **Effective in the treatment of pernicious anemia, including the neurologic complications.**
- **Effective in, and well tolerated by, patients sensitive to all liver preparations.**
- **Effective in extremely low doses, because of its high potency.**
- **May be administered parenterally in precise dosage, because it is a pure, crystalline compound.**
- **No known toxicity in recommended dosages.**

Literature is available on request.



Pernicious anemia before treatment with Cobione (Megaloblastic Bone Marrow)



Same patient ninety hours after a single injection of 0.025 mg. of Cobione

**Cobione is the trade mark of Merck & Co., Inc. for its brand of Crystalline Vitamin B_{12}.*

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The standards, together with methods and procedures designed to make observance possible, cover:

1. Hospital organization, operation and facilities;
2. Basic hospital rules and regulations—a model procedure for internal hospital management;
3. Qualifications for medical staff membership and hospital privileges; including staff departmentalization and chiefs of services;
4. Uniform system of hospital accounting and reporting of financial data;
5. Uniform system of recording and reporting professional activities, including professional audit, self-analysis, and comparison with other hospitals.

Cost of the Council

The total cost of the programs and services described is not very great—about one per cent of the 1948 operating expense of our member hospitals.

Medical Education	$23,000
Nursing Education	5,000
Hospital Administration Education	4,000
Hospital Surveying and Planning	8,000
Purchasing Program	11,000
Hospital Advisory	17,000
Medical Records	6,000
Uniform Accounting	6,000
Blood Bank	4,000
Public Relations	7,000
	$91,000*

Evaluation

The real evaluation of the program must come from the members, and from disinterested observers. However, it is safe to say, based on the many statements of appreciation that have been made by administrators, physicians, and trustees of both large and small hospitals, that all enjoyed and profited by the closer working relationships made possible by the Regional Council, and that a similar type of organization is strongly recommended to other hospitals and other regions.

**In accordance with a resolution passed by the board of directors of the Council, hospitals are asked to contribute funds on the basis of $50 for the first 50 beds or fewer, and $1 for each bed over 50. In this way an amount approximating 3 per cent of the operating budget was collected. Aside from the fact that the money was needed, it was considered psychologically sound for member hospitals to have some investment in the venture as it would increase their interest in the work of the Council.*

Job Analysis Might Aid Nursing Personnel

The existing acute shortage of nursing personnel has led to steady upward adjustments in salaries and continuous staff changes. One method that might be useful in helping to stabilize this situation would be the institution of a job analysis study in the various fields of nursing. Such a scientific approach to job evaluation might assist in promoting efficiency and establishing and cultivating better co-operation. It might be helpful, too, in reducing to some extent the present high turnover of staff. This is an approach that might well disclose considerable waste of trained nurses' professional skill in many of the duties they now perform and might lead to the greater utilization of the nurse-power. By itself, however, it probably would not be a factor of sufficient importance to solve the fundamental disequilibrium in the supply of and demand for nursing personnel in Canada.

—J. W. Willard, in "Public Affairs".

Council Meeting

(Concluded from page 70)

and keep down the number of very small units, even though so many villages were clamouring for them.

Red Cross Transfusion Service

The discussion on the Red Cross transfusion service was spirited, but displayed a desire on the part of all to work out a satisfactory solution. Testimony was presented from several areas indicating satisfaction with the arrangement, while others pointed out that it was not in the public interest that the Red Cross should insist upon the hospitals giving up their present blood banks until the Red Cross could prove its ability to meet the need. Dr. Stanbury and Dr. Rousseau were present by invitation and helped materially in the discussions. (Resolution No. 19.)

General

On Saturday afternoon, Lt.-Col. W. J. MacCallum, Ottawa, Assistant to the Civil Defence Co-Ordinator, gave a thought-provoking address on the place of hospitals in Canada's defence program. His remarks will be published in a later issue.

It is impossible in this brief sketch (far past our deadline) to mention every subject debated, or outline the views of all those who so generously contributed to the program. Notes on specific points raised will appear in other issues. Among the many welcome visitors were Mr. Dean Conley, Executive Secretary of the American College of Hospital Administrators, and Mr. John Hatfield, President-Elect of the American Hospital Association, who brought greetings from their respective organizations. Rev. Father Bertrand, President of the Catholic Hospital Council of Canada, took an active part in discussions.

Resolutions passed appear on page 44 of this issue.

Officers Elected

Honorary President: The Honourable Paul Martin, Minister of National Health and Welfare.

Honorary Vice-President: Arthur J. Swanson, Toronto.

President: R. Fraser Armstrong, Kingston.

First Vice-President: O. C. Trainor, M.D., Winnipeg.

Second Vice-President: A. C. McGugan, M.D., Edmonton.

Treasurer: A. L. C. Gilday, M.D., Montreal.

Executive Members at Large: Rev. Father H. L. Bertrand, Montreal; Rev. Sister M. Ignatius, Antigonish, N.S.; Percy Ward, Vancouver.

Executive Secretary and Editor: Harvey Agnew, M.D., Toronto.

Syringe Loss

Hamot Hospital, Erie, Pa., recently studied the financial loss entailed in failure to clean syringes and needles in warm water after use. It came to $650 a year. Biggest item was $250, resulting from "breakage in trying to separate when stuck from medication".—*Pa. H.A. News Bulletin.*

Rural Community

(Continued from page 33)

when undertaken conscientiously, can never be an easy task.

Besides giving the patient the best possible care from the point of view of his physical disability, the nurse in the small hospital has excellent opportunity at times for giving psychological help to those tried by sorrow as well as by pain. Again, the nagging thought that nobody cares can worry a patient into more than physical illness. The nurse can be an escape-valve for pent-up emotions. If she is wise and has a well developed personality, she can offer constructive advice. Every need is an opportunity and every opportunity is a responsibility. There is created between a good nurse and the patient a bond of understanding which makes for a desire to be helpful, on the one hand, and an eagerness to share one's troubles and receive advice, on the other.

The problems which worry or puzzle a patient may seem very simple to the nurse. Perhaps it is a question of feeding the older children or of caring for their minor ailments. An alert nurse will see that a mother goes home with a wider knowledge of how to handle her problems. In the case of a mother with a first-born child, the wise nurse will see that she knows how to prepare the baby's formula and care for the child properly. Moreover, in rural areas, the nurse will see that when the mother leaves she carries with her sufficient formula for the baby's first feeding. How great will be the appreciation of that mother when, after a weary journey, she has only to heat the formula.

Women's Auxiliary

The relationship between the nurse and the women's auxiliary can be very pleasant and profitable to each as well as to the hospital as a whole. A group of friendly, rustling women engaged in conducting a tea or a bazaar is an encouraging sign of healthy and happy relations between the nursing staff and the district. We are told that if we want to make a friend of a stranger, let him do a favour for us. There is no surer way of making friends for the hospital than by encouraging the women's auxiliary in their projects to embellish it.

Extra-mural Activities

The nurse will not taste real happiness until her giving exceeds her taking—until she is more concerned with what she can do to help others than with looking to others to help her. The nurse who has learned to adapt herself to the needs of the community can take the situation as she finds it, mould it to her own ends, and produce a worthwhile work, no matter how small the sphere may be. In her capacity of leader in the community, she can find numerous opportunities for instruction in hygiene. Groups are always to be found who are ready to attend classes in home nursing, first aid, and emergency care. Also, classes in pre-natal care are eagerly welcomed by expectant mothers. The nurse will find herself so occupied with the interests and problems of

(Concluded on page 98)

Need for Instruction in Fire Prevention

It is very easy to over-emphasize the importance of the classification of "Fireproof Buildings". There have been many lives lost in buildings which were correctly designated as fireproof structures. The building itself, the walls, flooring, structural parts, et cetera, may be actually fireproof; however, it is the equipment, drapes, and other furnishings which are highly inflammable.

Wherever the human element is so directly involved, it becomes essential that constant surveillance and supervision be exercised at all times. Hospital personnel cannot be made too much aware of the terrific dangers which are inherent in a hospital fire. They must be repeatedly cautioned and warned of the need to be constantly aware of the known hazards. With the high percentage of personnel turnover, it becomes necessary to have frequent instruction in the use of fire-fighting apparatus, the responsibility of each individual in the event of a fire, the nearest accessible emergency exit, and the many other responsibilities which must be assumed under emergency conditions. There is not sufficient time to think of all of these things when the fire has broken out and the personnel should be so drilled and trained that they act instinctively. — *Chicago Hospital Council Bulletin.*

Rural Community

(Concluded from page 96)

the district that she will look with surprise at the questioner who asks, "Don't you find it lonely in an isolated district?"

Many forget that life is largely what we make it. In the hospital, as outside, we live to learn. We are learners all our lives and the knowledge that serving others brings with it recompense in the form of quiet contentment is a lesson that the nurse soon makes her own. Compensating satisfaction through activity can be found in several ways—in the inspiration of service to one's community, in the inspiration of service to one's neighbour, and in the inspiration of service to Him who said, "As long as you did it to one of these, my least brethren, you did it unto me".

Laboratory Schools Recently Approved

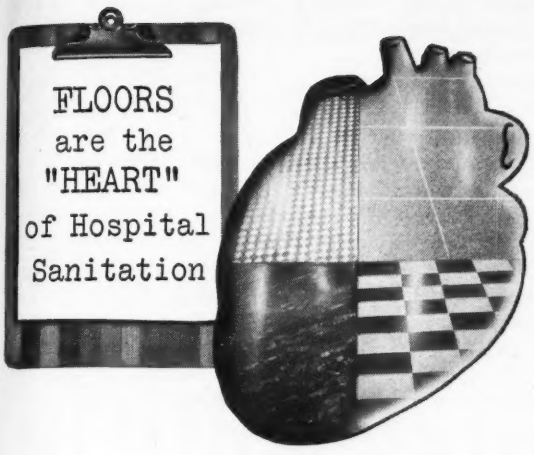
The Canadian Medical Association Committee on Approval of Schools for Laboratory Technologists has, in the past few weeks, approved laboratory schools in four more hospitals. These are as follows:

Hôpital Notre Dame, Montreal, Que.
Pierre Masson, M.D., director of laboratories.
Course: General Certificate.

Kitchener-Waterloo Hospital, Kitchener, Ont.
L. C. Fischer, M.D., director of Laboratories.
Course: General Certificate.

Grace Hospital, Windsor, Ont.
S. M. Asselstine, M.D., director of laboratories.
Course: General Certificate.

Shaughnessy Hospital, Vancouver, B.C.
H. E. Taylor, M.D., director of laboratories.
Course: General Certificate.



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2. WESTOLITE *Cleans* Cement, Concrete, Tile, Mastic, Asphalt, Slate, Quarry, Marble and unpainted Wood floors.	Balanced cleaning powder dissolves completely and quickly in water. Emulsifies many times its weight in grease. No scrubbing necessary. No suds to rinse. Safe to use, will not injure, stain or scratch surfaces.
3. CORO-NOLEUM *Disinfects and Deodorizes as it Cleans* all floors except rubber, soft mastic, or asphalt base tile.	Phenol coefficient of 7.5. Helps kill many germs and aids in the protection of Health. Ideal for operating rooms, washrooms and special wards. Economical to use.
4. LUSTRECLEAN *Cleans, Deodorizes and Lightly Waxes* Wood, Mastic, Linoleum, Cement, Terrazzo, Composition Tile, Asphalt Tile, Painted and Varnished Floors.	Essentially a cleaner but leaves a fine film of wax on surface. Deodorizing properties make Lustreclean a triple purpose product. Excellent for floors, walls and painted surfaces.
5. KWYKWAX *Waxes and Finishes* all types of floors, except Terrazzo.	No rubbing or polishing necessary. Dries in 20 minutes (or less) with a high hard lustre, which resists traffic wear, protecting floor surface.

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Provincial Notes

(Continued from page 68)

The $175,000 building with 43 beds and 11 cubicles replaces Carman's old general hospital of 26 beds.

* * * *

VITA. Efforts are being made to obtain a nursing staff for the Vita Memorial Hospital, a 20-bed institution operated by the United Church. Unless at least five nurses can be obtained, the hospital may have to close down until the situation can be alleviated.

* * * *

WINNIPEG. Thousands of citizens toured the new Shriners' Hospital for Crippled Children last month. The $450,000 two-storey brick building is situated on the Assiniboine River bank on spacious grounds. Accommodating 40 patients, the hospital contains a school room for patients under 14, a colourful playroom in the basement, and a concrete patio equipped with awnings and overlooking the river. The wards are decorated throughout with original and delightful murals.

WINNIPEG. A free x-ray examination service for all patients admitted is being inaugurated at the Winnipeg General Hospital. A new $8,000 x-ray machine has been installed in the admitting department to handle the estimated 17,500 chest examinations that will be made every year. While this is the first institution in Manitoba to adopt the free x-ray service, it is expected that the plan will be put into effect in four or five other hospitals within the next few months.

Saskatchewan

WADENA. On National Hospital Day, May 12th, citizens of Wadena were given an opportunity to inspect the newly equipped children's ward at Wadena Union Hospital. Decorated in peach and pale green with white woodwork, the ward contains four adjustable cribs in cubicles and three juvenile beds. Play pens, a high chair, a kindergarten set, a commode chair, a combination walker, and play table, are there for the use of the small patients. The ward was equipped by local Kinsmen at a cost of approximately $1,800.

Alberta

CAMROSE. Officially opened in April, the new $400,000 wing of St. Mary's Hospital adds 50 beds to the former 50-bed accommodation. Designed to match the old building, the new wing contains three fully-equipped operating rooms. Almost the entire top floor of the three-storey building is devoted to maternity cases. The hospital is operated by the Sisters of Providence and is served by seven doctors.

* * * *

CORONATION. Alterations and renovations to Coronation Municipal Hospital include interior painting, and new electric wiring with individual lights at each bed. In addition, a new x-ray machine is being installed at a cost of $4,500.

British Columbia

ALERT BAY. St. George's Hospital, towed in sections during the

(Concluded on page 102)

winter months to be reassembled in Alert Bay, was officially opened in April. The 60-bed structure houses, in addition to the usual hospital facilities, a paediatric ward, a doctors' clinic with diagnostic equipment, and an isolation ward. The total cost of moving and equipping the hospital was $160,000.

* * * *

ENDERBY. Provincial authorities have approved the construction of a new 15-bed hospital in Enderby. It is expected that the provincial and the federal governments will meet two-thirds of the total cost.

* * * *

NEW WESTMINSTER. The old building of the Royal Columbian Hospital will be renovated and remodelled to eliminate fire hazards. Fire drill and fire prevention regulations will be revised according to recommendations of the city fire marshal. The cost will be borne jointly by the municipal and provincial governments.

* * * *

PORT COQUITLAM . Plans for a 30-bed hospital to serve the town and surrounding district have been proposed and submitted for approval.

* * * *

VICTORIA. The federal government is planning to erect a 70-bed addition to the Veterans' Hospital in Victoria. The addition, which will be attached to the southeast side of the main building, will house patients who require only partial nursing care.

* * * *

WHITE ROCK. Negotiations are underway between the White Rock Hospital board and the Dominican Nursing Sisters of Everett, Wash., for a 75-bed hospital in that town.

C.H.C. Resolutions

(Concluded from page 66)

26. Support of Blue Cross

WHEREAS the Blue Cross organizations operating in Canada have provided an effective means whereby the people served may insure against the eventuality of illness and hospitalization costs by participating in a co-operative pre-payment plan; and

WHEREAS it is deemed desirable that the principle of individual enterprise and individual responsibility should be supported;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council continue to support and co-operate with Blue Cross organizations in every manner possible.

27. Contributory Health Insurance

WHEREAS, in the opinion of the Canadian Hospital Council, the individual should be encouraged to regard the costs of illnesses and hospitalization as a personal responsibility to the degree possible; and

WHEREAS, in the opinion of the Canadian Hospital Council, the principle of compulsory taxation for hospitalization and state control of hospitals is not in the best interests of either patients or hospitals;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council urge strongly that in the event the Federal Government deems it advisable to institute a plan for health insurance, that such plan be established on a contributory basis.

28. Dr. Albert E. Archer

WHEREAS the late Dr. Albert E. Archer, who died on May the twenty-third last, has made an outstanding contribution in the fields of medical practice, hospital administration, medical economics, and the social and religious life of Canada; and

WHEREAS Dr. Archer's kindly and warm personality has endeared his memory to many thousands of Canadians;

THEREFORE BE IT RESOLVED that the Canadian Hospital Council hereby express its appreciation of Dr. Archer's life work and further that our secretary be requested to forward a letter of sympathy to Mrs. Archer in her bereavement. ●

Theatre Proceeds for Hospitals

The Peterborough Summer Theatre has announced that the proceeds from its first year will be donated to the Civic Hospital and St. Joseph's Hospital. The season opens this month and is under the direction of Michael Sadlier.